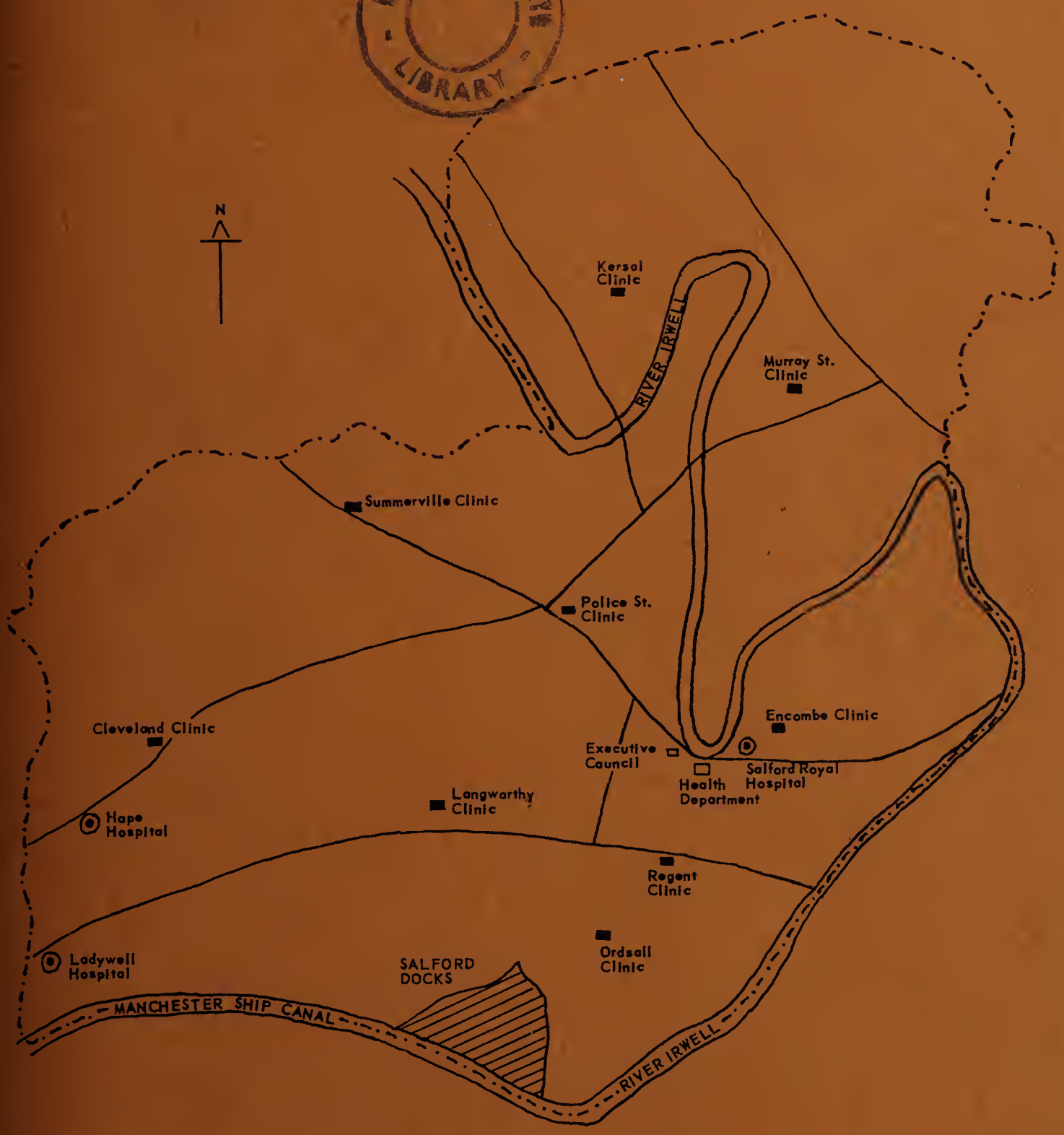
CITY OF SALFORD

ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH

1963



City of Salford

ANNUAL REPORT

OF THE

Medical Officer of Health

FOR THE YEAR

1963

BY

J. L. BURN, M.D., D.Hy., D.P.H.,

MEDICAL OFFICER OF HEALTH

CONTENTS

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at 31st December, 1963

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	F. G. LAWLEY, M.Ch.S., S.R.Ch.
	Miss A. E. OGDEN. A.Ch.S., S.R.Ch.
	Miss A. HARROW, A.Ch.S., S.R.Ch.

STAFF *(continued)*

2 EDUCATIONAL PSYCHOLOGISTS (PART-TIME) (MENTAL HEALTH)
3 REMEDIAL TEACHERS (PART-TIME) (MENTAL HEALTH)
17 GENERAL HEALTH VISITORS
6 HEALTH VISITORS (PART-TIME)
14 CLINIC NURSES (HEALTH VISITING)
14 NURSING AUXILIARIES (HEALTH VISITING)
5 APPROVED DISTRICT TEACHERS (MIDWIVES)
3 PREMATURE BABY NURSES
2 BREAST FEEDING SISTERS
16 MIDWIVES
4 MIDWIVES (PART-TIME)
6 QUEEN'S NURSES
2 STATE REGISTERED NURSES (DISTRICT NURSING)
5 STATE REGISTERED NURSES (PART-TIME) (DISTRICT NURSING)
5 STATE ENROLLED NURSES (DISTRICT NURSING)
1 STATE ENROLLED NURSE (PART-TIME) (DISTRICT NURSING)
1 NURSING AUXILIARY (DISTRICT NURSING)
5 NURSING AUXILIARIES (PART-TIME) (DISTRICT NURSING)
5 MATRONS OF DAY NURSERIES
2 PHYSIOTHERAPISTS
6 PHYSIOTHERAPISTS (PART-TIME)
4 SUPERVISORS OF TRAINING CENTRES (MENTAL HEALTH)
2 WARDENS OF HOSTELS (MENTAL HEALTH)
1 ASSISTANT AMBULANCE OFFICER

INTRODUCTION

MR. CHAIRMAN, LADIES AND GENTLEMEN,

I have pleasure in presenting the Annual Report for 1963.

The Health of the Environment –

Steady improvement has taken place in the environmental health of the people, due to continuing unremitting slum clearance, non-stop increase in control over smoke and in control of houses in multiple occupation. In food hygiene I must record disappointment at the slowness and inadequacy of our efforts – much remains to be done in practical education of food handlers, shopkeepers in general, and of every single person in particular in raising the standards of safety, cleanliness and purity of the food we eat and drink.

The Care of Mother and Child –

In personal and social hygiene the hard work continues. In the North West we face hazards to mother and child before, during and after birth which the more fortunate South does not seem to experience. The rates for still-births and deaths of babies in the first week of life are higher than in many towns due to factors some of which we know and some of which we are determined to find out. For the baby up to one year of age there are some deaths from respiratory disease due to the interaction of several factors – from poor housing conditions, lack of high standards of care by mothers, failure to get medical aid, to name but three aspects of a complex problem.

Curiously, at first sight, it would seem that in Salford in 1963 it was three times safer for a baby to be born illegitimate than from normal wedlock. The infant mortality rate of illegitimate babies was one-third that of legitimate. An important reason for this is the high standard of care given to these babies and their mothers – handicapped as they are, having the same physical, financial, emotional and social problems as their married sisters, but with no husband to give them support in many ways.

How different from 100 years ago where two-thirds of the "illegitimate" died before reaching their first birthday. The effort to remedy such deplorable neglect and cruelty of a century ago has had a remarkable result. I feel that far too little is done for the normal mother, just as in the case of housing for example, far too little is done for the ordinary family.

There is no need to dilate upon the aspects of health in which our services have been successful but to concentrate on the removal of the hazards to health, the continuing problem of bronchitis, the remorseless rise in lung cancer, the majority of which are preventable, and from cancer of cervix and breast in women. We must confront these grim facts in the hope that they will encourage people into health.

We are more and more interested in the borderland between clinical medicine and the health of the community. We must make the advances of modern medicine more available to more people. The pioneers of the past have proved that the clinical medicine of the present is the public health of the future.

In the Health Check-up (which in previous years we have called the Health Survey) we are measuring blood pressure, we are testing for defective vision, anaemia, diabetes and also for "pre-diabetes". However difficult this condition is, and however ugly the word, it is a very great problem in preventive medicine – to be able to foresee and forestall the anxiety of disabling disease. This is surely an attractive and exciting challenge, and we can accept it, using modern screening resources far more easily than the family doctor. We are there to assist him – all abnormal findings are sent to him; and we are able, with due caution, to reassure the "normal" individual.

This is a great gain, for we know that many people are secretly worried about disease. Some of them are already stiff (in more senses than one) with unnecessary anxiety. Far from filling people with phobias "making hypochondriacs" (as has been alleged in the past) we know that the fears and tensions are already there and it is wise to remove these anxieties by explanation and re-assurance. In this way we are able to help people into full health and safer, happier living.

No doubt there is much to learn about the tests used in a check-up of health, but we are learning some of the difficulties and some of the opportunities. We look forward to the day when every citizen is convinced that preventable disease is better prevented; that if the disease is present we must help him to take advantage of early, accurate diagnosis and prompt and adequate treatment.

I am sure the thanks of yourselves and all citizens of Salford should be expressed to the whole health team – the family doctors, when I have called upon them to help have responded fully – health visitors, midwives, district nurses, home helps, public health inspectors, mental health workers and the medical staff and consultants who advise us, as well as a large number of men and women of all grades whether in medical, nursing or administrative services or voluntary organisations who have helped. We do not forget all those members of the staff who do humdrum jobs which help in better health for the people.

Exactly 50 years ago a memorandum was received in Salford from the then Board of Education about *Schools for Mothers* and the attention was drawn to the large number of children who on their first admission to school were suffering from ailments and defects likely to retard their development, which were attributed to insufficient knowledge of the simple rules of health on the part of the mothers. Schools for Mothers were recommended as a means whereby the suffering and ill-health amongst pre-school as well as school children and in after life could be prevented. There is still insufficient knowledge of the simple rules of health.

Our present school for mothers – the Day Training Centre for those mothers with severe problems is a small aspect of our services of which you can be proud; with even a greater pride you can be conscious of the "front line" attack in the homes of the people of which the health visitor and her colleagues of the health team is the spear-head.

The general review of the mental health service with its story of progress

in the effective integration of local services and the research in progress in many ways is one in which you may rightly be proud.

I have the honour to be, Mr Chairman, Ladies and Gentlemen,

Your obedient Servant,

J. L. Brown

Medical Officer of Health.

HEALTH DEPARTMENT,
CRESCENT,
SALFORD, 5, LANCS.

Telephone: PENdleton 5891.

STATISTICAL SUMMARY – 1963

(Based upon figures supplied by Registrar-General)

Area – The City of Salford has a total area of 5,203 acres.			
Population – (Registrar-General's Estimate at Mid-year, 1963)			152,570
,, – (Census, 1961)			155,090
Density – The Mean Density of the City is equal to 29.32 persons per acre			
Live Births – Legitimate:	1,502 Males;	1,330 Females;	2,832
,, ,, – Illegitimate:	166 ,,	156 ,,	322
		Total	3,154
Live birth rate per 1,000 population			20.67
Still-births: 38 Males; 34 Females;			72
Still-birth rate per 1,000 live and still-births			22.32
Total live and still-births			3,226
Infant Deaths (deaths under 1 year) Legitimate 95, Illegitimate 3			98
Infant mortality rate per 1,000 live births – Total			31.07
,, ,, ,, ,, ,, ,, ,, – Legitimate			33.54
,, ,, ,, ,, ,, ,, ,, – Illegitimate			9.32
Neo-Natal mortality rate (deaths under 4 weeks per 1,000 total live births)			19.97
Early Neo-Natal mortality rate (deaths under 1 week per 1,000 total live births)			18.07
Illegitimate live births per cent. of total live births			10.21
Perinatal mortality rate (still-births plus deaths under one week per 1,000 total births) – Still-births 72; Deaths under one week 57 } Total, 129			39.99
Maternal deaths (including abortion)			3
Maternal mortality rate per 1,000 live and still-births			0.93
Deaths: 1,041 Males; 987 Females;			2,028
Annual rate of mortality per 1,000 of the population			13.29

TABLE 1

SHOWING THE BIRTHS IN THE CITY OF SALFORD, DEATHS OF LEGITIMATE AND ILLEGITIMATE INFANTS UNDER ONE YEAR OLD AND THE PROPORTION OF DEATHS UNDER ONE YEAR OF AGE PER 1,000 BIRTHS DURING THE YEARS 1942 TO 1963.

Years.	Births.			Percentage of Illegitimate Births to Total Births	Deaths under One Year.			Proportion of Deaths under One Year per 1,000 Births.		
	Total.	Legit.	Illegit.		Total.	Legit.	Illegit.	Total.	Legit.	Illegit.
1942	2823	2632	191	6·8	217	203	14	77	77	73
1943	3085	2863	222	7·2	214	203	11	69	71	50
1944	3251	3025	226	7·0	202	182	20	62	63	88
1945	3022	2749	273	9·0	183	168	15	61	61	55
1946	3849	3610	239	6·2	205	180	25	53	50	104
1947	4220	3973	247	5·9	258	240	18	61	60	73
1948	3761	3570	191	5·1	157	147	10	42	41	52
1949	3628	3387	241	6·6	193	181	12	53	53	50
1950	3354	3123	231	6·9	144	128	16	43	41	69
1951	3091	2881	210	6·8	107	103	4	35	36	19
1952	3100	2913	187	6·0	107	89	18	35	31	96
1953	2964	2794	170	5·7	95	83	12	32	30	71
1954	2867	2692	175	6·1	87	79	8	30	30	46
1955	2700	2544	156	5·8	81	75	6	30	29	32
1956	2826	2682	144	5·1	83	80	3	29	30	21
1957	3026	2851	175	5·8	88	84	4	29	29	23
1958	2930	2738	192	6·5	84	78	6	29	28	31
1959	2959	2789	170	5·7	71	67	4	24	24	24
1960	2991	2752	239	8·0	80	73	7	27	27	29
1961	3018	2769	249	8·3	85	79	6	28	29	24
1962	3199	2911	288	9·0	93	85	8	29	29	28
1963	3154	2832	322	10·21	98	95	3	31	34	9

TABLE 2

SHOWING THE BIRTH RATES, RATES OF MORTALITY FROM ALL CAUSES, TUBERCULOSIS OF RESPIRATORY SYSTEM, CANCER, HEART DISEASES, BRONCHITIS AND PNEUMONIA AND THE INFANT MORTALITY RATES DURING THE YEARS 1948 TO 1963

Years	Population estimated to middle of each year	Rates per 1,000 Population							Deaths under one year of age per 1,000 Births.
		Births	Deaths from						
			All Causes	Tuberculosis of Respiratory System	Cancer	Heart Diseases	Bronchitis	Pneumonia	
1948	178,100	21·12	11·81	0·78	2·16	2·44	1·14	0·48	41·74
1949	178,900	20·28	13·06	0·63	2·00	3·13	1·45	0·71	53·20
1950	177,700	18·87	12·87	0·50	2·31	3·51	1·30	0·46	42·93
1951	176,800	17·48	14·12	0·46	2·15	4·04	1·78	0·50	34·62
1952	176,400	15·57	12·19	0·35	2·12	3·35	1·33	0·59	34·52
Average 5 years		**18·66**	**12·81**	**0·54**	**2·15**	**3·29**	**1·40**	**0·55**	**41·40**
1953	173,900	17·05	12·36	0·29	2·24	3·24	1·59	0·74	32·05
1954	171,500	16·72	11·98	0·23	2·39	3·44	1·19	0·56	30·35
1955	169,300	15·95	12·30	0·22	2·08	3·46	1·33	0·78	30·00
1956	167,400	16·88	12·34	0·20	2·43	3·48	1·46	0·78	29·37
1957	165,300	18·31	12·97	0·19	2·44	3·75	1·37	0·79	28·75
Average 5 years		**16·98**	**12·39**	**0·23**	**2·32**	**3·47**	**1·39**	**0·73**	**30·10**
1958	163,600	17·91	13·20	0·12	2·20	3·70	1·56	0·84	28·67
1959	162,000	18·27	13·01	0·19	2·43	3·78	1·31	0·78	23·99
1960	161,170	18·56	12·67	0·13	2·44	3·60	1·21	0·62	26·75
1961	154,910	19·45	13·96	0·14	2·39	3·74	1·56	0·84	28·16
1962	154,000	20·77	14·90	0·08	2·42	4·23	1.67	0·91	29·07
Average 5 years		**18·99**	**13·55**	**0·13**	**2·37**	**3·81**	**1·46**	**0·79**	**27·33**
1963	152,570	20·67	13·29	0·06	2·41	3·38	1·42	1·15	31·07

TABLE 3

STATEMENT SHOWING NUMBER OF DEATHS IN THE CITY OF SALFORD FROM THE DISEASES SPECIFIED REGISTERED DURING THE YEARS 1933-1963 AND THE RATES PER 100,000 OF THE POPULATION.

(a) Number of Deaths. (b) Rate per 100,000 of the population.

Year	Bronchitis		Cancer (all sites)		Heart Diseases		Pneumonia		Tuberculosis of Resp. system		Total Deaths	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1933	200	92·2	339	156·2	591	272·4	269	124·0	248	116·0	3009	1386·6
1934	133	62·2	400	187·1	637	297·9	243	113·6	201	94·0	2932	1371·1
1935	131	62·4	348	165·7	656	312·4	236	112·4	190	90·5	2734	1301·9
1936	154	74·8	352	170·9	729	353·9	249	120·9	207	100·5	2893	1404·4
1937	141	69·9	390	193·3	779	386·0	245	121·4	178	88·2	2943	1458·4
1938	86	43·1	344	172·5	691	346·5	210	105·3	192	96·3	2611	1309·4
1939	92	46·8	366	186·2	838	426·2	201	102·2	187	95·1	2698	1372·3
1940	535	308·9	342	197·5	754	435·3	221	127·6	195	112·6	3224	1861·4
1941	333	208·5	276	172·8	559	350·0	211	132·1	173	108·3	2743	1717·4
1942	239	155·9	387	219·8	462	301·4	129	84·1	146	95·2	2223	1450·1
1943	330	215·7	345	225·5	445	290·8	147	96·1	148	96·7	2382	1556·9
1944	271	173·9	328	200·5	461	295·9	101	64·8	151	96·9	2271	1457·6
1945	416	264·5	313	199·0	472	300·1	126	80·1	146	92·8	2459	1563·3
1946	289	170·5	326	192·4	444	262·0	127	74·9	122	72·0	2266	1337·1
1947	288	165·5	351	201·6	488	280·3	122	70·1	131	75·3	2312	1328·2
1948	203	114·0	385	216·2	434	243·7	86	48·3	139	78·0	2103	1180·8
1949	260	145·3	358	200·1	560	313·0	127	71·0	113	63·2	2337	1306·3
1950	231	130·0	410	230·7	624	351·2	82	46·2	89	50·1	2288	1287·6
1951	314	177·6	392	221·7	715	404·4	89	50·3	82	46·4	2497	1412·3
1952	235	133·2	374	212·0	591	335·0	104	59·0	61	34·6	2151	1219·4
1953	277	159·3	390	224·3	563	323·7	129	74·2	50	28·8	2149	1235·8
1954	204	119·0	410	239·1	590	344·0	96	56·0	39	22·7	2055	1198·3
1955	226	133·5	352	207·9	585	345·5	132	78·0	38	22·4	2082	1229·8
1956	244	145·8	407	243·1	583	348·3	131	78·3	33	19·7	2065	1233·6
1957	226	136·7	404	244·4	620	375·1	131	79·3	31	18·8	2150	1300·7
1958	255	155·9	359	219·4	611	370·4	137	83·7	20	12·2	2159	1319·7
1959	212	130·9	394	243·2	612	377·8	127	78·4	31	19·1	2107	1300·6
1960	195	121·0	393	243·8	580	359·9	100	62·0	21	13·0	2042	1267·0
1961	242	156·2	370	238·8	579	373·8	130	83·9	21	13·5	2163	1396·0
1962	258	167·5	374	242·9	651	422·5	141	91·6	13	8·4	2294	1489.6
1963	216	141·6	367	240·5	516	338·2	176	115·3	10	6·5	2028	1329·2

CAUSES OF DEATH – Registrar General's Return of Deaths in the City of Salford during the year 1963

CAUSE OF DEATH	Sex	Total All Ages	Under 4 weeks	4 weeks & under 1 year	AGE IN YEARS								
					1 –	5 –	15 –	25 –	35 –	45 –	55 –	65 –	75 and over
Tuberculosis, Respiratory	M	8	–	–	–	–	–	–	–	4	2	1	1
	F	2	–	–	–	–	–	–	1	1	–	–	–
Tuberculosis, Other	M	1	–	–	–	–	–	–	–	–	1	–	–
	F	1	–	–	–	–	1	–	–	–	–	–	–
Syphilitic Disease	M	1	–	–	–	–	–	–	1	–	–	–	–
	F	–	–	–	–	–	–	–	–	–	–	–	–
Meningococcal Infections	M	–	–	–	–	–	–	–	–	–	–	–	–
	F	1	–	1	–	–	–	–	–	–	–	–	–
Other Infective & Parasitic Diseases	M	3	–	1	1	–	–	–	–	–	1	–	–
	F	3	–	–	1	–	–	–	–	–	1	–	1
Malignant Neoplasm, Stomach	M	37	–	–	–	–	–	–	–	6	7	19	5
	F	19	–	–	–	–	–	–	–	1	5	6	7
Malignant Neoplasm, Lung, Bronchus	M	99	–	–	–	–	–	–	1	9	50	29	10
	F	17	–	–	–	–	–	–	3	4	3	4	3
Malignant Neoplasm, Breast	M	–	–	–	–	–	–	–	–	–	–	–	–
	F	28	–	–	–	–	–	1	1	5	14	3	4
Malignant Neoplasm, Uterus	F	13	–	–	–	–	–	–	1	3	5	3	1
Other Malignant & Lymphatic Neoplasms	M	78	–	–	–	1	–	–	3	11	19	16	28
	F	76	–	–	–	–	–	1	1	11	13	21	29
Leukaemia, Aleukaemia	M	4	–	–	–	–	1	1	–	–	1	–	1
	F	5	–	–	2	–	–	–	1	–	1	1	–
Diabetes	M	2	–	1	–	–	–	–	–	–	1	–	–
	F	10	–	–	–	–	–	–	–	–	1	7	2
Vascular Lesions of Nervous System	M	95	–	–	–	–	–	1	3	6	15	26	44
	F	131	–	–	–	–	–	–	–	7	17	37	70
Coronary Disease, Angina	M	181	–	–	–	–	–	1	10	27	51	61	31
	F	115	–	–	–	–	–	–	1	5	28	33	48
Hypertension with Heart Disease	M	7	–	–	–	–	–	–	–	2	1	2	2
	F	15	–	–	–	–	–	–	–	–	–	6	9

CAUSES OF DEATH – Registrar General's Return of Deaths in the City of Salford during the year 1965 (*continued*)

CAUSE OF DEATH	Sex	Total All Ages	Under 4 weeks	4 weeks & under 1 year	AGE IN YEARS 1–	5–	15–	25–	35–	45–	55–	65–	75 and over
Other Heart Disease	M	64	–	–	–	–	–	2	1	6	7	17	31
	F	134	–	–	–	–	1	1	3	5	14	32	78
Other Circulatory Disease	M	51	–	–	–	–	–	–	2	3	10	18	18
	F	44	–	–	–	–	–	–	–	1	4	12	27
Influenza	M	6	–	–	–	–	–	–	–	–	2	1	3
	F	9	–	1	–	–	–	–	–	–	3	4	1
Pneumonia	M	69	5	11	4	–	–	–	1	2	8	10	28
	F	107	3	11	1	–	–	–	–	2	10	21	59
Bronchitis	M	150	–	–	1	–	–	1	3	10	29	59	47
	F	66	–	–	–	–	–	–	1	3	6	23	33
Other Diseases of Respiratory System	M	14	–	–	1	–	–	–	–	1	4	2	6
	F	8	–	–	–	–	1	–	1	1	–	2	3
Ulcer of Stomach and Duodenum	M	9	–	–	–	–	–	–	–	2	3	3	1
	F	7	–	–	–	–	–	–	1	–	–	2	4
Gastritis, Enteritis and Diarrhoea	M	5	–	1	–	–	–	–	–	1	–	–	3
	F	7	–	1	–	–	–	–	–	–	2	2	2
Nephritis and Nephrosis	M	2	–	–	–	–	–	–	1	–	–	–	1
	F	5	–	–	–	–	–	–	1	2	–	2	–
Hyperplasia of Prostate	M	5	–	–	–	–	–	–	–	–	1	3	1
Pregnancy, Childbirth, Abortion	F	3	–	–	–	–	–	1	2	–	–	–	–
Congenital Malformations	M	8	4	2	–	2	–	–	–	–	–	–	–
	F	12	6	3	–	–	–	–	–	–	1	–	2
Other Defined & Ill-Defined Diseases	M	89	33	–	2	1	–	–	2	7	8	12	24
	F	113	12	1	3	–	–	1	1	4	13	16	62
Motor Vehicle Accidents	M	18	–	–	3	2	2	2	2	2	2	2	1
	F	8	–	–	–	–	–	–	1	–	2	3	2
All Other Accidents	M	22	–	–	–	1	3	4	3	1	4	3	3
	F	25	–	1	–	–	–	–	3	1	2	5	13
Suicide	M	13	–	–	–	–	1	2	4	1	4	1	–
	F	3	–	–	–	–	–	–	1	–	1	–	1
TOTAL ALL CAUSES	M	1,041	42	16	12	7	7	14	37	101	231	285	289
	F	987	21	19	7	–	3	5	24	56	146	245	461

ENVIRONMENTAL HYGIENE

The year 1963 saw the work of the Public Health Inspector progress in all its various fields of activities; and a tribute must be paid to the dedication of the staff who have shown so much enthusiasm in carrying out their work.

Greater emphasis is being paid to the effect our activities have upon people. One must remember that, though records show that five or six hundred houses have been demolished, it is more important to consider that five or six hundred families have had to move their homes and re-habilitate themselves and become accustomed to new conditions and new neighbours. A Smoke Control Order may mean that a person has to become familiar with new methods of heating, and help and advice is needed during the initial stages. In the field of food hygiene whilst the drive for better kitchens, better equipment must still go on, it is important that the principles of hygiene should become part of the nature of the food handler.

Statistics are often a useful guide to the extent of work carried on in any particular field, and although some facts and figures are included in this report, I am of the opinion that no tabulation can show with any degree of accuracy the amount of thought, speculation, searching, manipulation, consultation, interrogation, arbitration and decision which goes into the everyday work of the Public Health Inspectors.

Although essentially impartial, the inspector often finds himself in the role of advisor to the misled, aid to the misused, friend of the co-operative owner and enemy of those who are not.

HOUSING: SLUM CLEARANCE AND IMPROVEMENT

The number of houses represented as unfit in clearance areas fell disappointingly during the year from the planned total of 1,500 to an achieved total of rather more than 700.

This reduction in representation was unavoidable and was brought about by the following reasons –

(a) The necessity to provide technical assistance and advice in mapping and referencing two large and complicated areas for redevelopment and river works purposes as follows :–

  (i) 338 properties of varying types including houses, shops, store-rooms, offices, banks, factories, theatres, licensed premises, garages, builders' yard and vacant sites on land of approximately 24 acres in extent,

  (ii) 69 properties and vacant sites covering a large and complicated area for the purposes of a private Bill authorising the Mersey River Board to construct works and acquire lands in connection with the diversion of the River Irwell within the City.

(b) The disruption to the programme brought about by the transfer of the

department to new premises on the Crescent, which delayed the representation of an area containing 450 properties until early 1964.

Whilst the assistance to other departments and bodies was willingly given it was nevertheless at the expense of the Slum Clearance representation programme and a major effort must be made to recover the ground lost.

Clearance Areas Represented During 1963

Area	No. of dwellings
Lissadel Street 1A, B, C Clearance Areas C.P.O.	174
Lissadel Street 2A, B Clearance Areas C.P.O.	535
Total	709

Orders Confirmed During the Year

Area	No. of Dwellings	Action
Hightown Clearance Area C.P.O.	536	Corporation Entry July, 1963 Rehousing commenced

It is significant to note that a series of compulsory purchase orders comprising properties for which Public Local Enquiries were held in February and May still awaited confirmation by the Ministry of Housing and Local Government at the end of the year.

4 Public Local Enquiries involving 11 separate Clearance Areas in 5 Compulsory Purchase Orders and comprising 1,286 separate dwellings were attended during the year. Senior public health inspectors (2) gave evidence on the condition of the properties and facilitated the admission of the Ministry Inspector to the properties concerned.

Unfit Houses Demolished or Closed During 1963
(including individually unfit houses)

	Dwellings	Persons Rehoused
1st quarter	293	632
2nd quarter	212	595
3rd quarter	208	789
4th quarter	174	682
Total	887	2,698

In addition 60 families from clearance area properties found their own accommodation during the year.

Rehousing (Removal and Disinfestation)

The Council carries out the removal of furniture and household effects of families from clearance areas to the new properties free of charge to the

families concerned and insists that disinfestation of furniture and the fabric of the vacated building shall be carried out by the Health Department's disinfestation service.

In September, 1963 the free removal and disinfestation service was extended to families occupying premises closed or demolished as Individually Unfit Houses.

Contracts for removal are let on a competitive tender basis and adequate safeguards under the Contractors Insurance Scheme are insisted upon to cover the authority against claims for loss or damage during removal.

Immediate Demolition Areas

The Council have accepted responsibility for minimising serious nuisances in properties awaiting demolition and for maintaining essential services. In general a piecemeal pattern of occupied or vacant and gutted houses gradually develops over each immediate demolition clearance area. The problem of maintaining essential services, particularly water supplies, and keeping roofs moderately weathertight is difficult especially where normal amenities are lacking in any case and the depressing and chaotic background of demolition and uncontrollable vandalism complicates the problem even further.

Block urgent repair job numbers are allocated to each clearance area and urgent jobs are attended to on a "minimum cost" basis by the workmen of the Direct Labour Building Department within 24 hours of being notified.

Safety is a major concern, particularly the problem of gas and electricity services in newly vacated premises. The liaison service with the Gas and Electricity Boards is thorough and competant; "cut off" teams from each service ensure the severance of supplies immediately upon vacation of the premises.

Interdepartmental Co-operation

Salford is fortunate in the high degree of co-operation existing between all departments of the Corporation concerned in the clearance of unfit houses.

The formation and regular meeting of the Housing (Slum Clearance) working party under the chairmanship of the Council's Senior Solicitor and comprising representatives from all interested departments ensures that all detailed proposals within the framework of the Council's overall approved programme are fully considered and discussed.

Improvement of Properties by Area

The basic necessity for the improvement of substantial numbers of houses in complete areas was outlined in the Annual Report for 1962. The early months of 1963 saw detailed consideration being given to the practical methods of implementing the Council's wishes and to the production of booklets, circulars and letters.

The initial approaches to owners, agents and tenants of all properties

comprised in the Seedley No. 1 Improvement Area was commenced in September. All owners and agents received composite packages of information relating to the improvement scheme and tenants were served with a letter informing them of the Council's plans for the area and requesting their co-operation.

All 70 owner-occupiers and 11 estate agents responsible for 155 houses were personally visited by a public health inspector. The reaction of all the owners and most of the owner-occupiers has been very favourable. There appears to be a small proportion of owner-occupiers firmly against our proposals at the present time mainly on the grounds of cost.

It is thought that at least twelve months intensive work will be required to effect the improvement of the worthwhile properties in this first area; it is planned to submit further areas to the Council for consideration at a rate of approximately 750 houses per year and it is proposed that work will progress simultaneously to provide an even flow of houses improved.

HOUSES IN MULTIPLE OCCUPATION

Extent of the Problem

There is no other aspect of the Public Health Inspector's work which gives so varied a picture of life and environmental health and hygiene as is found in the houses in multiple occupation of a large city. The houses range from the luxurious and resplendent to the downright squalid.

One recalls that until recently a certain well-known disc jockey occupied a flat in a converted Victorian mansion and graced its forecourt with his Bentley and E-Type Jaguar, and yet at the other end of the scale is the case of the stubbornly-independent man of 76 years who, for the last 20 years, has occupied a single attic room without cooking or personal washing facilities or even electric lighting for the princely rental of 2/6d. per week.

In between these two extremes there are a large number of families occupying cramped, barely sufficient accommodation affording only the barest essential facilities and greatly lacking in the privacy so essential for temporary escape from the bustling life of this seventh decade of the twentieth century. It must indeed be a difficult existence in the vast majority of these houses, where nothing is one's own and the responsibility for the all too often disgraceful condition of the common parts of the house are bandied about between rival tenants.

The advent of the Housing Act, 1961, has given the Local Authority power to ease the difficult problems arising in houses in multiple occupation, but as with most reforms a host of new problems arise whilst clearing away the debris of the old. The Act puts the responsibility for the management and well-ordering of the houses fairly and squarely on the shoulders of the owners, and the old excuse that these houses are what the tenants make them is fast becoming unacceptable.

It has been shown in the work carried out in this field by the Public Health Inspectors in Salford that given decent, clean living conditions with a fairly high standard of amenity, the vast majority of the tenants of these

houses are only too willing to keep up, if not improve, the standard so far achieved. However, one must state in fairness to some landlords, that there is yet a small minority of people living in multi-occupied houses who are no respecters of anything which is not their own, an important point in houses where shared facilities are the rule; but happily this is on the decline.

Action under the Housing Act, 1961, and its results

The Housing Act, 1961, has given the Local Authority extensive powers to eradicate the running sore of the squalid sublet house from the present day scene and implementation of these powers has shown some remarkable results. Of an estimated number of 250 multi-occupied houses in our City 160 have been inspected since the coming into operation of the Housing Act, 1961.

Probably the most startling result of action taken under this legislation is the number of houses which have changed hands, in many cases almost overnight and in all cases soon after notices were served requiring additional facilities and improvement in management. Out of the 160 houses inspected from May, 1961 to December, 1962 no less than 39 houses are known to have changed hands. It is by now no means unusual to receive applications from prospective purchasers for a search to be made surprisingly soon after notices are served on the original owners.

It would appear, therefore, that in many cases these houses in multiple occupation are owned either by persons without the means to manage them properly, or by persons who have the sole intent to extract as much profit as is possible from the houses with the minimum of outlay. We are fortunate in Salford to have various investment companies who are willing to take over this type of house, carry out extensive works often in excess of the standard required by the authority and also see that this standard does not flag. If extensive use of the Management Regulations results in more take-overs by these companies it will certainly make the Public Health Inspector's task much easier.

There is still a minority of owners who choose to ignore the notices with which they are served to improve conditions in their multi-occupied houses, but their time is running short. Authority to institute legal proceedings has been granted by the Health Committee in respect of 5 poorly managed houses for non-compliance with management orders and hearings are expected early in 1964.

Default Work and Compulsory Purchase

Although the local authority has the power to execute works in default of owners both for the provision of additional facilities and for work in connection with the Management Regulations, I am of the opinion that in cases where extensive default works are necessary, the use of the authority's power of Compulsory Purchase is to be preferred. This power has been exercised in respect of 6 large houses in the City. Two of these houses are of unknown ownership which until recently were multi-occupied but one of which is now vacant and the other occupied by one family. The owners of the remaining four houses have all for one reason or another stated their unwillingness to carry out the works required. In one case the house in

question had been purchased by agreement by the Authority and the building demolished in order to extend an existing housing estate into its large grounds providing space for 11 new houses.

The purchase of houses of this type will provide a useful reservoir of large-sized housing accommodation which can be used either for accommodation for families displaced from other houses in multiple occupation as a direct result of action being taken under the Housing Act, 1961 or as single units of accommodation for large families displaced as a result of the slum clearance programme ; a type of accommodation of which the Authority is desperately short at the present time.

There are a further 3 houses which were multi-occupied until action was taken under the Housing Act, 1961 but which now stand empty as a result of the owners' inability to afford to carry out the works required. Compulsory Purchase is being considered in respect of these houses also. In one case, however, a particular owner emptied his house, and unable to find a buyer, demolished it himself.

Appeals

As with all legislation, the individual is protected by his power to appeal against what he may think is unwarranted or unjustified action by the local authority. The individual also has a right to make representations to the Health Committee if he thinks the making of a Management Order is unnecessary. In the past year, seven owners have chosen to make representations to the Committee against the making of Orders, but in all but one case the Committee were satisfied that the making of the Orders was necessary. In one case the Committee accepted the owner's undertaking to carry out immediately the works required to bring the premises up to the required standard and also to keep the premises at all times in a condition which was satisfactory to the Public Health Inspector, without prejudice to the making of a Management Order should the standard of the house decline.

An appeal was made to the County Court in the early part of 1963 by the owner of a multi-occupied house against the requirements of a notice under Section 15 of the Housing Act, 1961 requiring the provision of additional facilities.

The premises in question were mainly owner/occupied but two rooms were let to single persons, one on the 1st floor and one on the 2nd floor. The existing facilities consisted of a wash hand basin in the 1st floor bathroom (which also housed the water closet) and two small electric pan heaters, one in the 1st floor room and one on the 2nd floor landing. Notice was served requiring the provision of a deep white sink with cold water supply within each letting and also suitably sized gas or electric cookers with ovens also within each letting. The Judge in this case upheld the appeal and ruled that the rooms were, in fact, 'reasonably suitable for occupation' having regard to the facilities available.

It is disturbing to note from recent law reports that similar action in a London borough has resulted in an appeal against a similar notice being dismissed and the Authorities' requirements of a sink with hot and cold water and cooking facilities within each letting upheld. The Judge in this

case made the point that this was the 20th century and the facilities required were reasonable in this day and age. I offer no opinion in these diverse findings.

Immigrant Multi-Occupied Houses

It would appear that Salford is fortunate in not having the problems associated with multi-occupation of houses by large numbers of Pakistani and Indian families as do other Northern towns and Cities, even as close as Manchester or as far as Bradford. Only three houses in the City are known to be multi-occupied by immigrants and in each case good co-operation was received from both the owners and the tenants in maintaining a high standard.

Basement Flats

Of three basement dwellings found in multi-occupied houses during the year, two have been subject to action under the Housing Act, 1957 to secure their closure. The remaining basement dwelling was entirely satisfactory.

The Future

It is envisaged that the coming year will see still more extensive work carried on in this field and should the recent Housing Bill become law there may be some even more remarkable results.

HOUSES IN MULTIPLE OCCUPATION

Total number of Houses Visited (1st Visit)		91 (499 lettings)
Total number of Inspections and Reinspections		492
Houses without sufficient Personal Washing Facilities		25
,, ,, ,,	Cooking Facilities	17
,, ,, ,,	Water Closet Accommodation	12
,, ,, ,,	Artificial Lighting to Common Parts of the House	11
,, ,, ,,	Ventilation to Common Parts of the House	2
Lettings without sufficient Artificial Lighting		3

NOTICES SERVED

Section 15 Housing Act, 1961 (Requiring Additional Facilities)	33
Section 90 Housing Act, 1957 (Requiring abatement of overcrowding)	4
Section 12 Housing Act, 1961 (Management orders made and applied for)	74
Section 14 Housing Act, 1961 (Requiring works to remedy neglect of proper management)	56
Informal Section 90 Notices (Giving maximum permitted numbers)	39

DRAINS AND SEWERS

During the year 2,576 complaints were received and inspections made in respect of choked and defective drains and sewers and dealt with by the Drainage Inspector. From this total 258 complaints were received from the Housing Department.

Simple blockages on all properties within the City are removed by the Drainage Inspector and his two assistants free of charge and Salford can claim to be one of the few places in the Country where this free service is in operation. The types of blockages referred to are the ones which can be removed easily by rodding from an inspection chamber or by plunging a gully.

The cold winter of 1963 when there were weeks without rain brought about numerous complaints of sewer gas from inside premises and in the streets. In several instances the gas was found not to be sewer gas but coal gas coming from broken gas mains and pipes caused by the frost. In the main the sewer gas complaints were confined to the older type of property and the source of complaint was usually the cellar drain which is always suspect. In this type of property experience has shown that practically all the cellar drains were constructed without cement jointing at the collars and in some instances egg shaped drain pipes are found which are only butt jointed. Consequently sewer gas can readily escape and seep through the clay and the joints in the flagging of the floor into the cellar. Occasionally it was found that the water in the cellar gully had evaporated and all that was required was to re-seal the gully with water. The City Engineer's Department spent a considerable time in flushing Public Sewers and erecting vent pipes to ventilate the sewers.

The City Engineer's Department carried out work to 65 sewers in respect of notices served by the Drainage Inspector where the cost of maintenance is recoverable under Section 24 of the Public Health Act, 1936. The purchase by the City Engineer of a mechanical digger has brought about a considerable saving of labour charges in excavations in places where it can be brought into operation and work can be completed much quicker.

During the year the Corporation carried out work at 36 premises in default of notices served in respect of choked and defective drains, which is a slight increase over the preceding year. At a number of these premises where work is carried out they are owner-occupied and usually they are unable to engage a private contractor or the contractor will not take on the work due to their financial status. More people are now buying houses and it is surprising the number of people who own houses who are of the opinion that their drains belong to the Corporation and are not their liability.

The Drainage Inspector's advice and assistance is always available to private contractors in removing blockages and in cases where there are serious defects requiring the reconstruction of a drainage system.

RODENT CONTROL

The control of infestation of rats in the sewer system of this City can be likened to the painting and maintenance of the Forth Bridge in Scotland – it never ends.

A three man team starts at one end of the City and works its way, inspecting, baiting and recording 3,137 manholes twice a year. Warfarin containing paranitrophenal is used and all manholes are baited until "no takes" are recorded. The "bag baiting" method – bait bags of muslin suspended by wire or sizal cord into the manholes – is still used and with this method accurate records are kept. The following table gives a summary of the year's work :–

Section of System treated	Total No. of manholes in the System	No. of manholes treated		No. of manholes showing takes		Weight of Bait taken in ozs.	
		36th maintenance	37th maintenance	36th maintenance	37th maintenance	36th maintenance	37th maintenance
Salford 1/13	929	872	886	31	83	90	232
Broughton 1/11	740	713	715	36	41	94	103
Pendleton 1/17	1,468	1,413	1,425	39	54	123	129
TOTAL	3,137	2,998	3,026	106	178	307	464ozs

36th maintenance 21. 2. 63 to 20.6.63
37th maintenance 26. 6. 63 to 31.10. 63

These figures are very encouraging and are substantiated by the fact that the number of surface complaints have dropped from year to year.

The following table gives some idea of the extent of the work carried out in the last few years using modern methods to combat these pests.

	RATS						MICE		
Type of Premises	Premises Visited			Treated			Treated		
	1958	1960	1963	1958	1960	1963	1958	1960	1963
Local Authority Premises	136	119	17	14	8	4	48	32	28
Dwelling Houses	11,478	6,942	345	599	252	98	591	341	191
Business Premises	1,773	2,523	80	124	54	26	240	140	136
	13,387	9,584	442	737	314	128	879	513	355

In 31 cases the drains were found to be defective and allowing rats to escape. Preliminary notices were served on the owners and in all cases the drains were repaired or old drains sealed off.

464 small boxes of Warfarin bait for mice were sold at the enquiries counter so that tenants could carry out their own treatment.

DISINFESTATION SERVICE

This section has dealt with many types of insect infestations during the year.

A nominal charge of 7/- per room is made to all occupants of dwelling houses who require the service irrespective of the type of infestation found. The money is paid to the operator who issues a receipt. In cases of hardship such as families on National Assistance and Old-Age-Pensioners a free service is given.

All other business premises are treated on the basis of "time and materials". Corporation Buildings and Hospitals in the City are also covered by this service.

Insects Attacked	Number of Operations in 1962	Number of Operations in 1963
Bedbugs	176	182
Cockroaches	576	302
Wood-boring beetles	2	5
Earwigs	5	–
Flies	12	16
Golden Spider beetles	5	9
Wasps	6	4
Fleas	9	7
Ants	2	3
Moths	1	3
Steam flies	8	21
Lice	12	10
Larder beetles	13	13
TOTAL	827	575

In addition to the 575 treatments for specific infestations, 924 slum clearance dwelling houses and lots of furniture were sprayed with insecticides prior to removal of the families to new homes. Also, fly-proofing as a precautionary measure was carried out at 21 school canteens.

1,419 tins of beetle powder were sold at the enquiries counter so that tenants could carry out their own treatment.

DISINFECTION STATION – LADYWELL HOSPITAL

Disinfection was carried out efficiently during the year. The following tables depicts the volume of work done.

	Beds	Laundry Bags
Infected bedding and clothing	415	496
Verminous bedding and clothing	67	197
Clothes of patients admitted to Ladywell Hospital	–	276
Beds and bedding from Ladywell Hospital	–	564
Eccles and Patricroft Hospital	12	156
Salford Royal Hospital	9	16
Hope Hospital	10	46
Stretford Health Department	–	1
Port Health Authority	–	4
Eccles Housing Department	146	159
Total	659	1,915

*The term laundry bag is a bag comparable with a kit bag and contains anythin from 20 to 40 articles.

Blankets from Ambulance Stations –	Salford	213
	Urmston	48
	Stretford	42
	Eccles	12
	Total	315
Sterilising apparatus and dressing drums from Ladywell Hospital		1,872
Private Firm – sterilising bags of rags for export		65

In addition to the above steam disinfection the following disinfection were carried out by spraying with formaldehyde:–

Salford Royal Hospital	22 cubicles
Dwelling houses	21
Ambulances	59
Ships' Cabins	8
Hospital Library Books	200

26 demonstrations for student nurses were also arranged.

SMOKE CONTROL

Review

This has been a year of changes involving firstly an acceleration o the Smoke Control programme, followed by a standstill in which no furthe areas were considered and finally by a complete re-assessment and chang of basis of smoke control appliances and costings.

The Ministry of Housing and Local Government reviewed the arrange ments under the Clean Air Act and local authorities were notified of th conclusions reached. The probable future availability of smokeless fuel was considered and it was found that in parts of the Country the supplie of open fire fuels would be insufficient to meet the estimated future requirements

If, therefore, the same reliance as hitherto continued to be placed on open fires in smoke control areas and if the local authorities' estimates of requirements are realised there would be insufficient open fire type of fuel. The Ministry go on to say that there is, however, no overall shortage of smokeless fuels, it is only the open fire smokeless fuels which are short. Some of the alternative smokeless fuels are in abundant supply. In particular there is plenty of hard coke which is in fact cheaper to use than open fire fuel.

The reduced production by Gas Boards of open fire smokeless fuel precipitated this occurrence which is due to a change in the manufacture of gas. Increasingly greater volume of gas will in future be produced from oil and this is supplemented by the importation of methane from the Sahara. It is therefore a foregone conclusion that coke production will diminish in proportion to the rate of conversion to oil gasification.

Revised Procedure and Fuels

Because of this the Ministry revised the grant arrangements and the definition of works of adaption considered reasonably necessary to convert fireplaces to burn smokeless fuel was widened to include replacement of existing appliances by closed or openable stoves. The same arrangements apply to any other type of appliance described as being suitable for hard coke burning. Freedom of choice is still given and the owner or occupier may still choose between solid fuel, gas, electric or oil burning appliances.

The effect of the foregoing will inevitably increase costs but there will, of course, be savings resulting from greater economy where solid fuel is used and a wider range of appliances qualifying for full grant where solid or other fuels are chosen.

The Ministry are in a difficult position and the previous tendency in grants has been towards economy, e.g. simple coke grates. The restricting of grant payment to simple coke grates must have deterred many people from installing stoves and other appliances now considered eligible and it is difficult to understand why this basis of grant assessment was ever introduced. Had the new arrangements applied since the passing of the Clean Air Act there would have been a greater variation in the smokeless fuels used in smoke control areas and local authorities would not find themselves in the most difficult and invidious position in which they are now placed.

The Ministry also say that supplies of open fire fuels for areas covered by confirmed smoke control orders can and will be maintained. In this respect the administrative difficulties of allocating open fire fuels to particular areas are very great and for the sake of those citizens residing in smoke control areas it is to be hoped that this confidence is not also as misplaced as the previous emphasis on open fire fuel.

Similarly one cannot help but think that unless the Ministry insist on the maintenance of fuel production to meet the demands from new areas then in a few years time another crisis may arise when further technological changes have taken place. Assurances on this point are vital if the smoke control programme is to succeed.

The Ministry refer to price trends and the development of new appliances

which are resulting in gas, electricity and oil becoming increasingly competitive in running costs as compared with the open fire fuels. This is very pleasing and is to be welcomed and coupled with the new grant basis will result in the use of a much wider range of appliances than those obtained hitherto.

Operative Areas

During the year two further areas have come into operation and there has been the usual run of completing outstanding work and the last minute deluge of applications. Even when a period of 18 months is given for adaptations there is always a large number of late applications. In spite of all literature, letters, visits and exhortations many people will not adapt until the last minute and work on the basis of "we are allowed to burn coal until such and such a date". There seems to be no way of spreading out the work over the period between confirmation and operation. The table below indicates the present position of smoke control areas.

Area	Acreage	Dwellings	Others	Total	Operative
Fairhope/Ladywell	28	459	–	459	1954
No. 1 S.C.A.	124	702	30	732	Nov. 1961
No. 2 S.C.A.	32	741	–	741	Oct. 1960
No. 3 S.C.A.	11	316	–	316	June 1960
No. 4 S.C.A.	7	210	4	214	Oct. 1960
No. 5 S.C.A.	378	3,105	73	3,178	Oct. 1962
No. 6 S.C.A.	335	2,441	200	2,641	July 1963
No. 9 S.C.A.	570	2,309	62	2,371	Nov. 1963
	Orders made but not yet confirmed				
No. 7 S.C.A.	345	5,800	296	6,096	Sept. 1965
No. 10 S.C.A.	298	1,697	772	2,469	Nov. 1964

Notices

Local authorities may authorise work after the date of operation of an order by the service of a notice. This cumbersome process should be amended except for cases in which the local authority are forcing the owner to do the work. To serve a notice merely to regularise grant payment is ridiculous yet without such notices grant would be refused to well meaning citizens. Where there is a genuine reason for a late application the authority's approval of the work should be adequate for payment of grant.

Offences

The law relating to use of fuel in smoke control areas is that it is an offence to emit smoke from any chimney except where that smoke is due to the use of an authorised fuel. The onus, therefore, is on the occupier. If a fuel merchant delivers other than an authorised fuel, the occupier is still responsible for any offence and it is easy to visualise circumstances whereby the most law abiding citizen will purchase coal, e.g. where the merchant tells the housewife he has only coal. Limitation of storage capacity is a compelling factor against stockpiling of fuel but income and expenditure is undoubtedly greater.

A merchant who wilfully delivers coal in a smoke control area is equally as guilty of an offence as the person who burns it. The administration of smoke control areas is difficult but they are rendered even more difficult by the merchants who refuse to stop delivering coal. Only a small proportion offend in this manner and very few houses purchase. Nevertheless, the provisions of the Clean Air Act should be widened so that action can be taken under that Act against any merchant knowingly delivering coal in a smoke control area.

Smoke Control — Impressions

The establishment of smoke control areas is now beginning to return dividends. The majority of residents are now so pleased with them that they would not burn coal under any circumstances even if allowed to and very few would even wish to return to the previous coal burning state of affairs. The cleanliness of the atmosphere has impressed most people very forcibly, and the freedom from smoke, soot and smuts has created the most favourable impressions. In fact one resident who organised a petition against smoke control areas is now very pleased with the cleaner atmosphere.

Less pleasing, however, is the question of price and whilst this must be related to cost of coal and production, smokeless fuels still represent a good buy. There is little ash, no soot or smoke, no unburnable lumps and the volume of 1cwt. of smokeless fuel is generally nearly twice as much as that of an equal weight of coal. By regulation of the draught control on appliances to adjust the heat output considerable fuel economy can be made.

AIR POLLUTION FROM INDUSTRIAL SOURCES

Salford is a highly industrialised city in which air pollution presents a major problem. The City is intensly developed with numerous factories, many with their own heating or steam raising plants. In much of the City the houses and factories intermingle so that in order to improve and clean up the air it is necessary to deal simultaneously with both houses and factories. Further, by including the factories in a smoke control area greater control is exercised over the plant arrangements and apparatus.

The first smoke control area containing 633 industrial and commercial premises has been surveyed with a view to the submission of an order to the Ministry of Housing and Local Government.

Much of the industrial plant in the proposed area and throughout the City generally is undergoing various forms of improvement. In particular where solid fuel is being eliminated it is generally replaced by oil burning plant. Where solid fuel plant is retained some form of mechanical stoking is fitted.

It is very apparent that much of the smoke from both industry and dwellings can be eliminated within a few years time. It is possible now to look over the City and observe a clear demarcation between smoke control areas and the remaining parts of the City which is not so controlled. A definite haze and smoke pall is noticeable over the latter and buildings are indistinct whilst the former are clear and bright with buildings sharply defined.

Chimneys

The large number of disused chimneys located in various parts of the City must cause a most misleading and somewhat unfavourable impression. As well as being unsightly and objectionable on aesthetic grounds the chimneys also tend to be used in a most unproper and dangerous manner. A number of cases have been discovered in which holes have been cut in the base of the chimney and in the main flue for the purpose of dumping rubbish and waste of all descriptions into the cavity and burning it there.

Incinerators

The need for properly designed incinerators fitted with after burners and arrestors cannot be stressed too strongly. Far too many companies still dispose of rubbish by means of periodic burning in the open, or in some form of unsatisfactory incinerator. In one instance a large area of the district was covered with a white deposit of light particles of very samll size. This occurred sporadically and investigation at various premises in the area revealed that the source of the trouble was a disused chimney in which steam proofed wallpaper was being burnt. During and after burning the paint fragments were carried away by the chimney draft.

It is essential that all companies are able to dispose of their waste materials but it is equally necessary for all waste to be burned smokelessly, without smell, emission of particles or nuisance.

Air Pollution — Future Trends

With the elimination of visible smoke virtually assured it is now necessary to consider how the various sulphur compounds can be reduced. These constituents are extremely harmful and cause considerable damage and corrosion. Just as it is essential to reduce smoke emission so it is of equal necessity to reduce sulphur pollution.

Where oil fuel is concerned the heavier grades contain the highest amount of sulphur, the proportions varying with the viscosity. From the public health point of view it is unfortunate that heavier grades of oil are cheaper than the lighter grades. Since there is a natural tendency to use the lower cost fuels with their higher sulphur content. To a certain extent the increase in price can be offset against the higher cost of heating the heavier oils before use in the furnace and the need for more frequent plant maintenance.

With increasing numbers of oil burning installations it is apparent that sulphur emission will be of a higher order and the use of grades containing the least amount of sulphur is to be desired. Where coal is used a washed coal containing less than 1% sulphur is preferable.

There is no legislation restricting the use of fuels to those of a specified sulphur content but it is suggested that a maximum of 1% sulphur in any liquid or solid fuel should be the aim. This is particularly applicable in the special review areas and more so in the highly industrialised parts of those areas and in which Salford is included.

LIQUID EGG (PASTEURISATION) REGULATIONS, 1963

These Regulations were made to ensure that bulked liquid or frozen egg is pasteurised before being used in the preparation of food for sale for human consumption (an exception is made for shell eggs broken out and freshly used on the same premises). The Regulations do not come into force until January 1st, 1964, and therefore do not strictly speaking come within the preview of the year under review. However for some time in the past I have been concerned with this matter, and it will be recalled that in my previous annual report I made reference to the fact that samples of liquid egg had revealed contamination with salmonella food poisoning and how representations had been made to the owner of an egg processing plant, resulting in all supplies of this commodity from this source being pasteurised. During the past year my Inspectors have continued this type of work and have regularly visited bakehouses in the City and have submitted samples of liquid egg for the alpha-amylase test which denotes the efficiency of pasteurisation. If samples did not satisfy the alpha-amylase test, return visits were made to the bakehouse and the importance of using a pasteurised liquid egg was stressed. In some instances opposition was expressed and the view put forward that pasteurised egg did not give sufficient "lift" to certain types of confectionery, but I think that the methods of pasteurising used to-day should result in a product satisfactory for the requirements of the trade.

The result of these efforts was to ensure that the groundwork had been laid to make for a successful advent to the Regulations.

BACTERIOLOGICAL SAMPLING OF FOODSTUFFS

Ice Cream

Regular routine samples were again taken from producers in the City and producers from outside retailing in the City. Results generally were good and follow-up visits were made when results fell below the required grade. A depot has been established in the City for the management of a fleet of soft ice cream vehicles operating over a large portion of south-east Lancashire. Regular visits have been made to this depot and spot checks made on the vehicles in conjunction with sampling of the products.

Milk

Samples were taken from all supplies distributed in the City. However, for the same reasons outlined in the section on Food and Drug sampling, it is felt that the intensive sampling of this product is not as essential as formerly required. In view of this, future sampling, although covering all sources of supply, will be somewhat curtailed. The results obtained during the year proved all supplies to be satisfactory both as regards keeping quality and efficiency of pasteurisation and sterilisation.

Samples of milk bottles have also been taken to ensure that bottle washing is efficient. Where total counts exceed 600 these can be regarded as unsatisfactory and are usually due to weak detergent strengths or low detergent temperature.

Desiccated Coconut

Samples were again taken throughout the year following the heat-treatment of this product at a plant operating in this City. No sample taken revealed contamination with salmonellae organisms and coliform checks showed that efficiency of heat-treament was being maintained.

Samples were also taken from bakehouses and from retail sales.

Cooked Meats

Samples of cooked meats were taken from food preparation premises in the City. Although there is no recognised standard, total bacterial counts help to give a picture of methods employed in food preparation and advice can be given on hygienic aspects in this field.

FOOD HYGIENE

The work in connection with the enforcement of the Food Hygiene (General) Regulations, 1960, has continued throughout the year. Return visits have been made and in general the improvements enforced during the initial survey of food premises has been maintained. Premises which have shown to require more attention than others have been placed in a special category and more frequent visits have been made to this type of premises. Increased attention has been paid to food trading carried on from vehicles and also on delivery vehicles themselves. Many of these vehicles are operating from premises outside the City boundaries and in cases where it has been necessary to draw the attention of the owners of these vehicles to contraventions of the Regulations, letters have also been sent to the various local authorities concerned in order that they may take appropriate action. Where plans have been submitted for approval by the Building and Development Committee, these have been inspected by the Department to ensure that structural provisions involving the Food Hygiene (General) Regulations, 1960, are complied with. This has been especially useful in respect of cafes and restaurants in connection with the provision of water closet facilities for customers. In these cases it is often difficult to make provision afterwards if account has not been taken of this during the initial planning of the premises.

In the work carried out it has generally been possible to secure the co-operation of the various occupiers of food businesses in promoting improved standards. In some cases, however, the threat of legal proceedings has been necessary to secure compliance, and in three cases legal proceedings were instituted. These are described as follows :–

(1) Summonses were issued against the owner of a cafe in the City for contraventions of the Food Hygiene (General) Regulations. These could not be proceeded with as the person owning the cafe became domiciled in the Republic of Ireland and was outside jurisdiction. This cafe has since been sold and the necessary work carried out by the new owner.

(2) Summonses were issued against a food wholesaler. The premises were generally unsatisfactory and rat droppings were found amongst foodstuffs stored. A fine of £20 was imposed.

(3) Summonses were issued against the owner of a vehicle used for retailing poultry. The interior of the van was in an insanitary condition and had been used for eviscerating of chickens without a water supply. The equipment was also in a dirty condition. A fine of £15 was imposed.

SAMPLING UNDER THE FOOD & DRUGS ACT, 1955

The present tendency for the food industry to be concentrated in fewer hands and with greater checks being applied by food chemists employed by manufacturers has been no doubt largely responsible for the decrease in adulteration in recent years. To-day obvious adulteration has been replaced by wrong and misleading descriptions on labels. Legislation, however, has increased and having regard to this a definite sampling policy must be established. When legal action is taken following an unsatisfactory sample, the Section of the Food and Drugs Act usually involved is Section 2 which makes it an offence to sell food which is not of the nature, not of the substance and not of the quality demanded by the purchaser. To enable this section to be used other factors have to be taken into consideration and sampling to a plan having these factors in mind will give a balanced sampling programme. A simple method of sub-division could be as follows :–

(1) Foods for which specific legal standards have been made for compositional quality. These include milk, cream and ice cream, coffee, fish paste, fish cakes, jams and other foods subject to the various food standards, codes and regulations.

(2) Foods for which there are no exact legal standards but which have been subject to codes of practice between food manufacturing organisations and the Ministry of Food and also where it can be established by other means that a compositional standard is reasonable for that particular food. An example of this is beef and pork sausage, and Courts have upheld the view that 50 per cent and 65 per cent meat content is a reasonable standard for this type of product.

(3) Pre-packed articles generally to secure compliance with the provisions of the Labelling of Food Order, 1953, and to check labels which could be of a misleading nature.

(4) Foods in which preservatives are allowed. The preservatives allowed in food are prescribed in the Preservatives in Food Regulations, 1962. In some cases preservatives have to be declared and sampling will reveal if the Regulations are being observed.

During the year, 1,091 samples were taken under the Food and Drugs Act, 1955. Towards the latter end of the year a change in the intensive milk sampling policy was instituted. In view of the decline in milk adulteration due to strict control within the dairy industry and milk testing schemes introduced by the Milk Marketing Board in respect of farmer's milk, it is felt that intensive sampling of this commodity is no longer the necessity it used to be. However, checks will continue to be made on all sources of supply. This change will enable more time to be spent on other products. The change will be apparent in the statistics of the next annual report.

There were three prosecutions during the year.

(1) A sample of beef sausage contained 42.5 per cent of meat and the City Analyst gave an opinion that beef sausage should contain at least 50 per cent meat. The local manufacturer stated in evidence that as there was no legal standard he was of the opinion that he could not be forced to comply with this standard. The Stipendiary Magistrate stated he thought this standard was a perfectly reasonable one and the defendant was conditionally discharged and warned that it was expected that the meat content of his beef sausage should be increased to 50 per cent.

(2) Five loaves which were part of a consignment delivered to a shop in the City and which had been sold to different customers were found to be heavily contaminated with mould. Enquiries revealed that this bread had been baked five days previous to the delivery. Some days later another loaf delivered by the same bakery to another shop in the City was similarly found to be affected with mould. The bakery firm in question pleaded guilty and a fine of £30 was imposed.

(3) A complaint was received of a small white loaf purchased in the City containing some foreign matter. The City Analyst certified this to be mice droppings which had been baked into the bread. A visit to the bakery revealed mice droppings on the floor of the bakehouse. The owner of the bakehouse was found guilty and a fine of £25 was imposed.

INSPECTION OF UNSOUND FOODS

During the year routine visits have been paid to both wholesale and retail food premises in the City and advice given as to the suitability for sale of all types of food. The growth of the use of frozen food cabinets has resulted in opinions being required as to food fitness where refrigeration has broken down. In these cases the food is not always unfit for human consumption, but the peculiar nature of this type of product would result in rising temperature affecting the marketing of the food and it would obviously be against the interests of the retailer to continue to sell it in this state. Where it is not possible to state that this food is unfit the procedure is adopted of issuing a certificate to the effect that the food has been surrendered following a breakdown in refrigeration machinery.

The following table shows a list of food surrendered for destruction during the year.

Meat	6,607 lbs
Vegetables	990 ,,
Fruit	3,060 ,,
Soup	30 ,,
Evaporated Milk & Cream	150 ,,
Creamed Rice	126 ,,
Sausage	17 ,,
Fish	45 ,,
Fowl	12 ,,

Cheese	40 lbs
Bacon	12 ,,
Liver	3 ,,
Coconut	200 ,,
Chicken Necks	8,277 ,,
Dried Fruit	30 ,,
	19,599 lbs

FOREIGN BODIES IN FOOD

The question of foreign bodies in food is giving increasing cause for concern. In many cases the evidence is insufficient to place responsibility directly upon the manufacturer and it is important from a legal point of view to obtain a complete chain of evidence before contemplating legal proceedings. Whether to prosecute or not should depend on evidence of negligence and if the foreign body itself is objectionable and harmful. One is aware that food manufacturers in general are greatly concerned over this aspect and much effort is spent in methods of prevention and in instruction to staff employed.

Some of the more interesting complaints of this nature received during the year are set out below.

Evaporated Milk (Complaint of Alcoholic Smell)

This was submitted in a small bottle, the original tin having been thrown away. There was an odour resembling methylated spirit and on submitting to analysis it was found that 0.056% w/v of alcohol was present. The manufacturer, a reputable national firm, could give no reason for the presence of this alcohol.

Balm Cake (Fibres Baked into Crust)

Microscopic examination revealed this to be hessian sacking fibres and investigation showed that the bakehouse in question used sacking to rough clean the baking trays. A warning letter was sent to the bakery and they were urged to take precautions against this.

Bar of Chocolate (Containing Moth Larvae)

This bar of chocolate was found to contain one insect larvae which was identified as that of the flour moth. The remainder of the stock in the shop was examined and found to be sound. The bar of chocolate in question was the last of a consignment and checks with the manufacturer revealed that this particular bar had been manufactured some months previously. A warning letter was sent to the shopkeeper concerning correct rotation of stock.

Biscuits Contaminated by Odour

A complaint was received that some biscuits purchased had been contaminated by an odour which has been prevailing in this area. This odour was airborne and prevailed in the Weaste Area for some days. The biscuits in question had been displayed without cover in the shop and had absorbed this particular odour. They were withdrawn from sale.

Tin of Tomatoes Containing Insect Larvae

A complaint was received that an insect larvae had been found in a tin of tomatoes. Examination revealed that this was the larvae of the "Bordered Straw" a common pest of tomato plants in the Mediterannean Area. The larvae burrows into the heart of the tomato and is extremely difficult to detect.

Small Loaf Containing Mice Droppings

This has already been reported in the section under Food & Drugs Act sampling. Legal proceedings were instituted and a fine of £25 imposed.

Gateau (Containing Domed Screw in the Filling)

This complaint was received from a person who had bought a piece of gateau at a cafe in the City. When eating it she had bitten upon the screw which was in the filling of the cake. An inspection of the bakehouse and the method of making this article revealed that it was unlikely to have gained access at the bakehouse. As it was thought that insufficient precautions had been observed by the vendors legal proceedings were instituted. A conviction was obtained but an absolute discharge was granted on payment of £5. 5. 0d. costs.

Filter Tip of Cigarette on Meat Delivered to a Canteen

A complaint was received that a filter tip of a cigarette had been found embedded into the outside of a shoulder of lamb, part of a consignment delivered to a canteen in the City. The meat had been delivered some hours before this was found, so there was insufficient evidence to warrant any formal action. The supplier was notified and warned of the consequences of this type of offence.

Fly Found in a Drum of Table Salt

This insect was found in a plastic drum of salt. The packers stated that the salt was delivered by tanker and fed into a hopper prior to the filling of the drums. A warning was issued concerning future offences.

SWIMMING BATH WATER

Three hundred and thirty samples of swimming bath water were taken from four public swimming baths and from a swimming bath situated in one of the City's schools. The samples taken are divided into one for chemical examination and one for bacteriological examination. Of the samples taken 27 were found to have too high a chlorine content than was necessary to safeguard health and 20 were found to have too low a chlorine content to give protection against bacterial pollution. When a result of this type is obtained the manager of the baths concerned is immediately informed and a copy of all results is sent to the Baths Superintendent as a matter of routine.

The method of chlorination used in the public baths is to make up bleaching powder in the form of a bleach liquor and this liquor is taken into the baths on the intake valve. Frequent tests of the water should be taken every day and determinations of both free chlorine and pH value recorded

WATER SUPPLY

Water supply is obtained from Manchester Corporation's reservoirs and during the year 13 samples of this supply were taken as a result of complaints. Analyses showed the supply to be satisfactory both as regards chemical and bacteriological standards. The complaints were due to brownish discolouration of the water caused by an excess of iron oxide. Representations to the water department resulted in these matters being rectified.

An interesting complaint during the year was from a block of multi-storey flats where a number of complaints had been received of deposits of foreign matter issuing from the hot water taps. This foreign matter was found to be algae, a species of plant life. During the summer the reservoirs supplying this area had been affected with algae and it is possible that this type of growth found its was into the hot water cylinders during this period. Here it would die, sink to the bottom and would not be apparent until the cylinder had been emptied and refilling caused agitation of the remains at the bottom of the cylinder. Samples from the main storage tanks proved this supply to be clear. The only remedy was disconnection of the hot water cylinders followed by cleaning and flushing.

FOOD POISONING

Only five individual cases of persons affected with food poisoning organisms were notified and there have been no mass outbreaks. Although it is now several years since I had to report incidents of this kind, there is no cause for complacency and it is only continued diligence in all aspects of food hygiene and in correct preparation and storage of food which will continue to keep this very good record.

TINNED STEEL FRYING PANS

I should like to make brief reference to my previous annual report when I discussed at some length the risk of contamination of food by the use of tinned steel frying pans where the "tinning" consisted of impure tin.

This matter was referred by the Association of Municipal Corporations to the Ministry of Health and at the time of writing, the Home Office are in the process of discussions with the various trade organisations with a view to ensure safety of pans imported into the Country as well as those manufactured here. Particular importance has recently been attached to this subject by the view expressed recently that medical research had indicated a connection between the ingestion of lead and of some cases of mentally handicapped children.

SHOPS ACT, 1950

Health and Welfare Facilities

Sections 37 – 39 of this Act which are concerned with the health and comfort arrangements for shop works have been repealed and replaced by the Offices, Shops and Railway Premises Act, 1963. The demise of this part of the Act will not be lamented, as its inadequacies are well known to all concerned. The replacing Act preserves all the benefits of this Act, and in addition gives far greater protection in a way which should render enforcement more practicable.

Closing Hours and Sunday Trading

The shop closing hours and Sunday trading restrictions are not affected by the new legislation, despite the obvious need for review.

During the course of this year a bitter controversy has raged between certain trades which illustrates the irrelevance of the Act to modern conditions. This controversy was about the humble dish of fish and chips. Briefly the difficulty is that fish and chips may not be sold in a fish and chip shop on Sundays. This prohibition is generally welcomed by traders because it gives them guaranteed leisure without loss of trade. Unfortunately, automation has arrived in the fish frying world in the form of mobile vehicles, equipped to cook and sell fish and chips, and several such vehicles have been operating in the City on Sundays. Numerous representations have been made to the Health Department about this, but it is firmly established in law that a vehicle is not a shop nor even a place. The ludicrous position has therefore arisen that you may sell fish and chips on Sunday from a vehicle, but not from a shop.

There are indications that a review of this Act is to take place at national level, and it is hoped that this review will at last result in some realistic changes.

Employment of Young Persons

The Act restricts the hours of work of persons under the age of 18 years, to ensure that sufficient time is available for rest and leisure pursuits.

In most types of shops contraventions are rare because of the modern trend to shorter opening hours.

Contraventions have been found in the case of ladies hairdressers however, where there is a tendency in some establishments to exploit young girls by working them for long hours on low wages. Theoretically these young persons are receiving training, but in one case the proportion of staff was 1 adult hairdresser to 3 young girls under the age of 16 years. Strict enforcement of the law was insisted upon in this establishment, including the display of records of hours actually worked, as in busy periods there was an obvious incentive to work the young persons for longer hours than legally allowed.

OFFICES, SHOPS AND RAILWAY PREMISES ACT, 1963

The passing of this Act on 31st July, 1963, was a recognition by Parliament that the health, safety, and welfare of office and shop workers, ought to be guaranteed by statute.

In a general way the requirements follow a similar pattern to the existing Factories Acts, although a complete assessment cannot yet be made because many of the Sections are to be developed further by Regulations to be made soon. The following brief summary is a guide to the main points covered:–

Cleanliness

This applies to premises, furniture and fittings, and it is likely that

specific reference to regular interior decoration will be made in the Regulations.

Overcrowding

Rooms in which staff are employed must not be so overcrowded as to cause injury to health, and with certain exceptions there must be at least forty square feet of floor area per person employed.

Temperature

A reasonable temperature must be secured and maintained, and a temperature of less than 16 degrees Centigrade (60.8°F) shall not be considered reasonable. There is no maximum prescribed temperature, but extreme cases of high temperature could be dealt with as being not reasonable. Rooms to which the public are admitted are exempted, as also are rooms where goods of a perishable nature are stored, subject to the provision of a place where staff may resort for the purpose of warming themselves.

Ventilation

Effective provision must be available and this may be more specifically defined later by Regulations.

Lighting

Effective provision must be made in both passages and workrooms, and in cases where natural lighting is used regular cleaning of skylights and windows must take place.

Sanitary Conveniences

Suitable and sufficient conveniences shall be maintained at places conveniently accessible to the staff, and the conveniences shall be kept clean, well lighted and ventilated. Specific standards will probably be laid down by Regulations.

Washing Facilities

Proper facilities to include hot water, soap and suitable means of drying must be provided.

Drinking Water

An adequate supply of wholesome drinking water must be available.

Accommodation for Clothing

Both storage accommodation and facilities for drying clothing is required. The Regulations may prescribe a standard of arrangements for drying clothing if the Minister so decides.

Sitting Facilities

Seats must be available for staff in the proportion of at least 1 seat to

three staff. In cases where the type of work is such that a substantial part of it can be done sitting down, then a seat must be provided for each person employed.

Floors, Passages and Stairs

All floors, passages and stairs to be in good repair, kept free of obstruction and in the case of stairs to be provided with hand rails.

Eating Facilities

In the case of shop premises only, facilities for eating meals shall be provided where required.

Dangerous Machines

The provisions include fencing of exposed dangerous parts, training of staff, and a restriction on the employment of young persons to clean dangerous machines. Machines likely to be covered by this Section include bacon machines and paper guillotines.

Health and Safety

The Minister has wide powers to make special Regulations for protecting employees against risks of bodily injury, or injury to health arising out of equipment or any substance used in any process.

Noise and Vibration

Regulations may be made to control noise and vibrations.

Prohibition of Heavy Work

Regulations may be made prescribing maximum weights which employees may lift in the course of their work.

First Aid

In all premises to which the Act applies a first aid box must be provided. If more than 150 persons are employed, then the first aid box must be in the charge of a person trained in first aid treatment and always available during working hours.

Fire Precautions

The Act gives comprehensive powers to Fire Authorities to require where necessary, means of escape, fire alarms, and in certain cases fire prevention measures. In certain types of premises a fire certificate has to be obtained from the Fire Authority.

ENFORCEMENT

Premises where only self-employed persons or relatives of the employer work, are exempted from the Act, as also are premises where less than a

total of 21 hours per week are worked. This will have the effect of exempting a large number of small shops.

The act is to be enforced by local authorities in the majority of premises, but in the following categories the Factory Inspector is to enforce :–

1. Premises occupied by local authorities

2. Premises in but not part of a factory

3. Premises at docks and wharves.

A preliminary survey has revealed the following approximate number of premises in this City where the City Council is to be responsible for enforcement :–

Shops including wholesale shops	3,200
Public Houses	265
Betting Offices	100
Bank Branches	45
Offices	550
	4,160
Deduct premises where no staff are employed	1,600
Total	2,560

In addition to the above the Factory Inspector will be responsible for enforcement in approximately 1,250 premises.

Registration of premises is to commence on 1st May, 1964, and it is anticipated that the Act will be brought into force with effect from 1st August, 1964.

ANIMAL BOARDING ESTABLISHMENTS ACT, 1963

This Statute was enacted on 31st July, 1963, and is to commence on 1st January, 1964.

Premises used to provide accommodation for other people's dogs or cats are required to be licensed, with the object of protecting the welfare of the animals accommodated.

The City Council have approved the following conditions of licence :–

1. Accommodation provided for animals must, in all respects, be suitable as regards construction, size of quarters, temperature, lighting, ventilation and cleanliness.

2. All dogs and cats accommodated at the premises must be provided with suitable bedding material and facilities given for adequate exercise.

3. Animals shall be adequately supplied with suitable food and drink, and visited at suitable intervals.

4. The Licensee shall ensure that a responsible person shall at all times be in or within a reasonable distance from the premises. In the case of lock up premises, the name and address of the reponsible person shall be prominently displayed on the front door or window of the premises, and the responsible person must have a key to the premises in order that the necessary steps can be taken in the event of fire or other emergency.

5. All reasonable precautions must be taken to prevent and control the spread of infectious or contagious diseases among the animals including the provision of adequate isolation facilities.

6. Appropriate steps must be taken for the protection of animals in case of fire or other emergency.

7. All bulk supplies of dog biscuits or meal must be kept in rat proof containers.

8. A register must be kept containing a description of any animals received into the establishment, date of arrival and departure, and the name and address of the owner. Such, register to be available for inspection at all times.

9. The owner of the animal boarding establishment shall permit an authorised officer of the local authority to inspect the premises at all reasonable times.

10. The number of animals accommodated must not at any time exceed the number specified on the licence.

Careful enquiries have revealed only two premises in the City which are used for the boarding of dogs and cats. Negotiations are in progress with proprietors concerned, with a view to securing compliance with the above conditions. Applications for licences will be considered by the Health Committee early in 1964.

PET ANIMALS ACT, 1951

There are 16 premises in the City which are used for the sale of pet animals.

Regular inspections are made to ensure that the animals are properly accommodated and treated. No serious cases of cruelty or mismanagement have been found during this year. Warnings have been given, however, in two cases about the practice of leaving lock up shops unattended, and without any indication in the window as to where the key could be obtained in the event of fire or other emergency.

HAIRDRESSERS AND BARBERS

A register of all hairdressers and barbers is kept as required by the Salford Corporation Act, 1955, with the object of securing a high standard of hygiene. The following is a summary of the requirements of the bye-laws :–

Premises

(a) Cleanliness,
(b) Regular interior decoration,
(c) Sound floor coverings,
(d) Covered receptacle to be provided for sweepings.

Equipment

(a) To be clean at all times,
(b) Suitable sterilising facilities to be available and equipment to be sterilised at least once per day,
(c) Adequate hot water supply to be available,
(d) Clean towels.

Personal

(a) Cleanliness,
(b) Clean overalls
(c) Waterproof dressings to be used by the hairdresser to cover any boil or open sore.

Inspections are made to ensure compliance with the bye-laws, and as a general rule it has been found that the majority of premises comply with the bye-laws. In some premises, however, there is some slackness about the important matter of sterilising instruments. Almost invariably it is in gentlemen's saloons that this slackness occurs and it is proposed to stress this matter during the survey which is to take place next year.

STATISTICS

Complaints and Notices

Complaints received	9,615
Statutory Notices issued	3,587
Statutory Notices abated	2,999
Intimation Notices issued	1,227
Intimation Notices abated	836

Nature of Inspections

Sanitary Defects	17,673
Sublets (Houses in Multiple Occupation)	492
Common Lodging Houses	17
Caravans	73
Factories with Power	337
Workplaces	13
Shops Act Inspections	292

Nature of Inspections (continued)

Cinemas and Theatres	5
Public Conveniences	720
Places of Entertainment	38
Piggeries	7
Pet Shops	23
Pharmacy and Poisons Act	37
Motor Vehicle Exhaust	68
Diseases of Animals Act	142
Dairies	248
Food Shops	183
Food Stalls and Vehicles	481
Food Preparing Premises	277
Restaurants and Snack Bars	336
Canteens (Factory and School)	57
Unsound Food	356
Food Samples	316
Infectious Diseases	33
Food Poisoning	47
Smoke Observations	546
Smoke Abatement	7,315
Industrial Boiler Plants	171
Disinfestations	924
Housing Act Inspections	2,776
Improvement Grant Inspections	393
Rodent Control	644
Pest Act	236
Public Houses	568
Food Shops Survey	1,409
Swimming Bath and Drinking Water	231
Miscellaneous	684
Noise Nuisances	9
Total	38,177
Calls (No admittance)	4,319

RESULTS OF MILK SAMPLES

Test	Milk	Number Tested	Passed	Failed	% Failure
Phosphatase	Pasteurised	149	149	—	—
,,	T.T. Pasteurised	153	152	1	.60
Turbidity	Sterilised	113	113	—	—
Methylene Blue	Pasteurised	149	142	7	4.92
,,	T.T. Pasteurised	153	145	8	5.22
	T.T.	46	43	3	.65
T.B. Inoculation	Pasteurised	—	—	—	—
,,	Raw Untreated	9	9	—	—

ICE CREAM — RESULTS OF SAMPLES

Number of Samples	*Grades*
56	1
17	2
6	3
3	4

LIST OF SAMPLES TAKEN

Food and Drugs Other than Milk	362
Milk for Phosphatase Test	302
Milk for Methylene Blue Test	357
Milk for Fats and Solids-not-fats etc.	690
Milk for Turbidity Test	113
Ice Cream	106
Fertiliser and Feeding Stuffs Act Samples	17
Water Supply Samples	11
Swimmimg Bath Water Samples	351
Rag Flock Samples	2
Miscellaneous Samples for Bacteriological Examination (including Desiccated Coconut, Liquid Egg, Cooked Meats, etc.)	660
Total	2,971

REGISTERED FOOD PREMISES

The following are the number of food premises by type registered under Section 16 of the Food and Drugs Act and the number of dairies registered under the Milk and Dairies Regulations, 1959 :—

Dairies	6
Butchers' shops manufacturing sausages and cooked meats	50
Fish and Chips shops	118
Ice cream manufacturing premises — hot mix	5
cold mix	4
Ice cream shops	736
Butchers' shops	192
Bakehouses	81

In addition it is estimated that there are about 1,500 food shops and other food premises which are not subject to registration.

FACTORIES ACT, 1961

(1) Inspections for purpose of provision as to health :–

Premises	No. on Register	Number of		
		Inspections	Written Notices	Occupiers Prosecuted
1. Factories in which sections 1, 2, 3, 4 & 6 are to be enforced by local authorities	107	1	–	–
2. Factories not included in (1) in which section 7 is enforced by the local authority	963	336	77	–
3. Other premises in which section 7 is enforced by the local authority (excluding outworkers premises)	–	–	–	–
Total	1,070	337	77	–

(2) Cases in which defects were found :–

Particulars	No. of cases in which defects were found			
	Found	Remedied	Referred to H.M. Inspector	Referred by H.M. Inspector
Want of cleanliness (S.1)	–	–	–	–
Overcrowding (S.2)	–	–	–	–
Unreasonable temperature (S.3)	–	–	–	–
Inadequate ventilation (S.4)	–	–	–	–
Ineffective drainage of floors (S.6)	–	–	–	–
Sanitary Conveniences (S.7)				
(a) Insufficient	5	3	–	–
(b) Unsuitable or defective	108	5	–	25
(c) Not separate for sexes	16	4	–	–
Other offences against the Act (not including offences relating to outworkers)	–	–	–	–
Total	129	12	–	25

OUTWORKERS

Section 133

Number of outworkers in August list. Required by Section 110(1)	104
Nature of work : Making etc. of wearing apparel	104
Making etc. of brass and brass articles	–
Number of cases of default in sending list to Council	–
Number of cases of prosecutions for failure to supply list	–

Section 134

Number of instances of work in unwholesome premises	–
Number of notices served	–
Number of prosecutions in respect of outworkers' premises	–

CITY ANALYST'S SECTION

TOTAL SAMPLES EXAMINED

During the year, 3,884 samples were examined in the City Laboratory; they may be classified as follows :–

	City of Salford	*Borough of Eccles*	*Borough of Stretford*	*Borough of Sale*
Food & Drugs Act Samples	1,091	133	105	88
Fertilisers & Feeding Stuffs Act Samples	28	–	–	–
Swimming Bath Waters	330	28	–	–
Miscellaneous Samples (including Contract Samples from the Central Purchasing Committee)	248	1	–	3
Atmospheric Pollution tests	1,829	–	–	–
	3,526	162	105	91

Total :– 3,884

FOOD AND DRUGS ACT, 1955

New Regulations, Ministry Reports and Recommendations made during 1963

1. In the Soft Drinks Regulations 1963 several changes have been made in the existing Regulations and some of the recommendations made by the Food Standards Committee in the Report on Soft Drinks have been implemented.

The standards of composition have been revised and for many products the sugar content has been increased; the amount of saccharin has been reduced and the presence of saccharin must be declared on the label. Descriptions of soft drinks are now controlled; for example a "crush" is defined as a soft drink intended for consumption without dilution, and a "squash" is one intended for consumption after dilution; in the case of flavoured, carbonated drinks it is forbidden to use on the label any word or device suggestive of any fruit unless the suffix "ade" or the word "flavour" follows the name of the fruit.

2. The Bread and Flour Regulations, 1963 –

(a) prescribe permitted ingredients for various types of bread and requirements for the composition of bread containing milk solids or added protein,

(b) re-enact, with amendments, the Flour (Composition) Regulations, 1956,

(c) impose requirements for labelling certain breads and impose restrictions for claims about slimming and weight reducing properties,

(d) prohibit the sale of flour or bread containing added colouring matter, except that flour and bread other than white or soda bread may

contain caramel, and the sale of flour containing any bleaching or improving agent other than a permitted one,

(e) control the labelling of permitted bleaching and improving agents.

3. The Liquid Egg (Pasteurisation) Regulations, 1963 require the pasteurisation of liquid egg for use in food, other than liquid egg which is removed from the shell on the food manufacturer's premises and used within 24 hours. The Regulations also prescribe a test which must be satisfied by pasteurised eggs.

4. Two Reports by the Food Standards Committee of the Ministry of Agriculture, Fisheries and Food were published during the year.

In the Report on Meat Pies it was recommended that a standard of not less than 25% meat should, with provisos for pies within certain weight ranges, apply to meat pies; meat and vegatable pies including such products as "Cornish Pasty" and "Forfar Bridie" should contain not less than 12½% meat, unless they are clearly labelled with the name of the vegetable alone or with the name of the vegetable first.

The Report on Antioxidants reviews the Antioxidant in Food Regulations, 1958 and recommends some changes in the list of permitted antioxidants and the foods allowed to contain antioxidants.

5. A National Survey has recently been carried out to determine the incidence of penicillin and other antibiotics in milk. In a report on the results of this Survey, the Milk and Milk Products Technical Advisory Committee of the Ministry of Agriculture, Fisheries and Food expressed concern at the wide-spread use of antibiotics in the treatment of mastitis, and the possibility of a public health hazard arising due to the presence of traces of them in milk. One of the recommendations made by this Committee was that food and drugs authorities should be encouraged to sample and test ex-farm milks for the presence of antibiotics, and to take appropriate action.

FOOD AND DRUG SAMPLES

Most of the samples submitted for analysis are purchased by the Sampling Officer in the normal manner, just as a private purchaser would do; these are known as informal samples. Some samples are, however, taken formally by the procedure set out in the Food and Drugs Act, i.e., the sample is divided into three parts, each of which is sealed, one is given to the vendor, one is submitted to the Public Analyst and the third part is retained by the Sampling Officer for future comparison.

Also included in the informal samples are those foods and drugs which have been purchased by private individuals, found to contain extraneous matter or to have undergone spoilage and have then been submitted for examination. In the following report samples pre-fixed by the letter "A" were taken formally and those by the letter "B" informally.

Table 1 classifies the samples examined under the Food and Drugs Act during the year and shows the number of unsatisfactory ones. Once again,

meat products showed the highest proportion of unsatisfactory samples; in most cases these were low in meat content when compared with the recommended standards.

Of the 1,091 samples examined 1,060 had been taken by the Sampling Officer and the rest were 'complaint' samples submitted by private purchasers. The total number of unsatisfactory samples represents a rate of 6.2 per cent, but if the rate is worked out for only those samples taken by the Sampling Officer, a much lower figure of 4.4 per cent is obtained.

TABLE 1

Samples examined under the Food and Drugs Act during 1963

Samples	*Number examined*	*Number adulterated or irregular*
Alcoholic Beverages—other than Spirits	1	Nil
Baking Powder	2	Nil
Bread	10	10
Butter	4	Nil
Cereals and cereal products	10	1
Cheese and cheese products	7	Nil
Chocolate confectionery	2	Nil
Coffee and coffee products	7	Nil
Colouring matter, etc.	3	Nil
Drugs	31	2
Eggs	8	Nil
Fats etc.—other than butter or margarine	4	1
Fish products—canned	6	1
Fish products—other than canned	6	1
Flour confectionery—other than bread	6	1
Fruit—canned	12	1
Fruit—dried	37	9
Fruit—fresh	6	Nil
Fruit—crystallised	2	Nil
Fruit—juice	2	Nil
Ice-cream	18	1
Margarine	1	Nil
Meat products—canned	30	11
Meat products—pies	9	2
Meat products—sausages	17	2
Meat products—others	17	1
Milk—examined for compositional quality		
(a) ordinary	626	12
(b) Channel Islands	64	Nil
Milk—others	10	2
Milk—evaporated	9	1
Milk products—other than above	6	Nil
Nuts and nut products	2	1
Oils	1	Nil
Pickles	4	1
Preservatives	1	Nil
Preserves	16	Nil

TABLE 1 *(continued)*

Samples examined under the Food and Drugs Act during 1963

Samples	*Number examined*	*Number adulterated or irregular*
Puddings	1	Nil
Sauces	4	Nil
Soft drinks	10	2
Soups	3	Nil
Spices, condiments and herbs	17	Nil
Spirits	8	1
Sugar, syrup, etc.	1	1
Sugar confectionery	5	Nil
Sweetening tablets	3	Nil
Table jellies, desserts	17	2
Vegetable products – canned	16	Nil
Vegetable products – dried	3	1
Vegetable products – fresh	4	Nil
Vegetable products – juice	2	Nil
Total	1,091	68

MILK

The standards for quality of ordinary milk are fixed by the Sale of Milk Regulations, 1939. These are not absolute standards, but if a milk falls below the values specified, namely, fat 3.0 per cent and non-fatty solids 8.5 per cent, it shall be presumed, until the contrary is proved, that the milk is not genuine by reason of the abstraction of fat or non-fatty solids or the addition of water. Of the 626 ordinary milks analysed for this purpose, 12 were reported against. Ten of these had fat deficiencies, ranging from 3.3 to 20 per cent; one was low in non-fatty solids and contained 0.8 per cent extraneous water, and one was incorrectly labelled Channel Islands, although it was sold as ordinary milk and actually was ordinary milk. Further samples were found to be satisfactory in all cases.

The standard of composition for Channel Islands milk is fixed by the presumptive standards of quality which apply to all milks, and by the Milk and Dairies (Channel Islands and South Devon Milk) Regulations, 1956, which stipulate an absolute standard of 4.0 per cent fat. All 64 milks in this category were satisfactory.

The rates of milk adulteration i.e. 1.9 per cent for ordinary milk and nil for Channel Islands milk, are very low and represent a satisfactory state of affairs. This is only to be expected, however, as most of the milk supplied in the City is from one of the several large distributors in the area and the milk is, therefore, subject to close quality control. Consequently, it has been the policy recently to reduce the milk sampling rate and to increase the rate for other food and drug samples.

If a milk is low in non-fatty solids it is submitted to the Hortvet freezing-

point test. This gives evidence as to whether the deficiency is due to the presence of extraneous water or whether the milk is naturally poor in non-fatty solids. During the year, 21 samples were found to be low in non-fatty solids due to natural causes.

In addition to examining for compositional quality, during the latter half of the year certain milks were tested for the presence of traces of antibiotics. 24 samples were tested and all were free from antibiotics.

The average composition of the milks analysed is given in table 2, the corresponding figures for the previous five years being given for comparison.

TABLE 2

Average composition of Milks

	1958	*1959*	*1960*	*1961*	*1962*	*1963*
All Milk (other than Channel Islands)						
Fat %	3.69	3.53	3.62	3.61	3.57	3.58
Non-fatty Solids %	8.82	8.63	8.68	8.65	8.68	8.72
Total Solids %	12.51	12.16	12.30	12.26	12.25	12.30
Channel Islands Milk						
Fat %	4.77	4.66	4.63	4.86	4.67	4.66
Non-fatty Solids %	9.05	9.00	8.92	9.14	9.21	9.20
Total Solids %	13.82	13.66	13.55	14.00	13.88	13.86

UNSATISFACTORY FOOD AND DRUG SAMPLES (other than Milk)

Details of the unsatisfactory foods and drugs (other than milks examined for compositional quality) are given in table 3; these numbered 56 out of a total of 401 samples examined in this category.

TABLE 3

Unsatisfactory Food and Drug Samples (other than Milk)

Serial Number	*Description*	*Nature of adulteration or irregularity*	*Remarks*
B860	Desiccated Coconut	Irregularly labelled	Packers notified
B898	Dried apple rings	Large piece of crumpled paper, resembling dried apple, present.	Packers interviewed
B918	Pork sausage	12.3% deficient in meat	Butcher interviewed Further sample satisfactory
B935	Canned casserole meat	Deficient in meat compared with the recommended standards	Further samples taken
B997	Canned beef steak		

TABLE 3 *(continued)*

Unsatisfactory Food And Drug Samples (other than Milk)

Serial Number	*Description*	*Nature of adulteration or irregularity*	*Remarks*
B1025	Apricots, dried	790 parts per million of sulphur dioxide in excess of maximum allowed	Stock withdrawn from sale
B1028	Currants	An excess of grit present	Packers notified
B1029	Flour	Slight excess of prepared chalk present	Further sample satisfactory
M139	Sardines, canned	Contained green algal matter, probably due to inadequate cleaning before canning.	Canners informed
B1081	Halibut-liver oil capsules	Oil content of capsules below B.P. specification	Further sample taken
B1146	Currants	Excess of grit present	Packers notified
B1175-8	Dried apricots	All contained sulphur dioxide in excess of the maximum allowed	Supplier informed, all existing stocks withdrawn from sale
B1181	Currants	Irregularly labelled	Label to be corrected
B1210	Herbal tablets	Recommended as a medicine but the containers did not bear labels giving the necessary declarations	Vendor thought to have moved to another area. The local authority for that area informed
B1222	Dried mixed vegetables	Sulphur dioxide present but not declared in the list of ingredients	Packers notified. Label changed
B1318	Meat Pie	34 per cent deficient in meat compared with the recommended standards	Manufacturers cautioned Further sample satisfactor
M153	Corned beef	Meat badly discoloured due to corrosion of the can	Packers notified and interviewed
M170	Milk	Contaminated with 0.6 gramme of soil	Dairy representatives interviewed & cautioned
M213	Sugar	0.32 per cent salt present	Referred to neighbouring authority as the article had been purchased there
M226	Minced Meat	Had deteriorated somewhat	No action advised
M242	Pickled red cabbage	Had undergone excessive microbio-logical spoilage	Existing stocks checked but found to be satisfactor
B1387	Ice-cream	60 per cent deficient in fat	Formal sample taken but found to be satisfactory Manufacturer cautioned

TABLE 3 *(continued)*

Unsatisfactory Food and Drug Samples (other than Milk)

Serial Number	*Description*	*Nature of adulteration or irregularity*	*Remarks*
M288	Evaporated milk	Small amount of alcohol present	No action advised as the alcohol could have come from the bottle in which the sample was submitted
B1412	Meat pies	19 per cent deficient in meat	Manufacturer cautioned Further sample satisfactory
M317	Milk	Mould growth in bottle	Dealer interviewed
M318	Bread	Contaminated with undue amount of burnt crumb	No action advised
B1438	Canned loganberries	Filled weight of fruit substantially lower than the recognised minimum filled weight	Further sample satisfactory
M319	Bread	Loaf affected by mould growth	Baker interviewed and cautioned
B1490-4 B1669	Wrapped, Sliced bread	All heavily contaminated with mould	Legal proceedings instituted £30 fine
A1285	Beef sausages	15 per cent deficient in meat	Legal proceedings instituted. Defendant given discharge on the understanding that the meat content be increased to the suggested minimum standard of 50 per cent
B1636	Cream cookie	Interior of cake contaminated with atmospheric dust	Baker interviewed
B1667	Part of contents of can of stewed steak	Contained a high proportion of salt	Sample from same batch quite satisfactory. No further action taken
B1668	Bread	Contaminated with mouse droppings	Legal proceedings taken Fine of £25
B1597 1627 1634	Canned meat products	All slightly low in meat compared with the recommended standards	Further sample satisfactory
B1718	Salmon spread	Slightly low in fish content	Repeat sample satisfactory
B1763	Irish stew, canned	Slightly low in meat content	Further sample had satisfactory meat content
B1791	Lemon drink	Misleading label	Manufacturer notified label to be changed
B1798	Cocktail sausages, canned	Starch present but not listed in ingredients	Importers informed
B1799	Canned ham and tongue	Misleading label implying that the product was all meat, whereas it was only 75 per cent meat	No further stock Wholesaler had gone out of business

TABLE 3 (*continued*)

Unsatisfactory Food and Drug Samples (other than Milk)

Serial Number	*Description*	*Nature of adulteration or irregularity*	*Remarks*
B1800	Minced ham and chicken in jelly	Slightly low in meat compared with the appropriate code of practice	Further sample taken and found to be satisfactory
B1818	Part of white loaf	Contained large patches of dirty dough	Bakery inspected and warning letter sent
B1819	Pineapple crush	Contaminated with a film of bacterial growth	Manufacturers notified
B1866 1867	Table jellies	Patches of foreign matter present in the tablets	Remaining stock withdrawn from sale
B1875	Flaked beef suet	Slightly low in fat	Repeat sample satisfacto
A1293	Rum	Contained the equivalent of 5.7 per cent extraneous water when compared with the declared strength of 70° proof	Brewery notified

FERTILISERS AND FEEDING STUFFS ACT

To safeguard purchasers of substances used for fertilising the soil or for feeding to cattle or poultry, it is necessary under the above Act, when selling any specified fertiliser or feeding stuff, to give a statement declaring particulars of composition, etc. The amounts of the constituents declared must, within certain specified limits of variation, agree with the results found by analysis.

Nine fertilisers and nineteen feeding stuffs were examined during the year and of these, all the fertilisers and fifteen feeding stuffs were satisfactory. Of the four unsatisfactory samples, two had an excess of protein, one a deficiency of oil, and one an excess of fibre. In all four cases the variation outside the specified limits was not sufficiently great to take any action other than notifying the manufacturers accordingly.

SWIMMING BATH WATERS

At the various swimming baths in the City, treatment is continuously carried out to control the quality of the water. Samples are taken regularly from the baths and examined to ascertain, among other things, that an effective level of chlorination is being maintained. This must be sufficient to give adequate protection against bacterial pollution introduced by bathers but should not be so high as to cause complaints of smell, taste or irritation.

Three hundred and thirty of these samples were submitted during the year.

MISCELLANEOUS SAMPLES

Of the 248 miscellaneous samples examined during the year, 201 were submitted by the Central Purchasing Committee. These consisted of articles such as cleaning materials, polishes, detergents and various foodstuffs and they are examined to see that they conform to specifications which have been made out, thus ensuring that satisfactory products are obtained at competitive prices.

Some of the more interesting of the remaining 47 items in this class were:

Frying Pans: Several of these were purchased to examine the tinning for lead content following on the work done on this type of article towards the end of 1962 and mentioned in last year's report.

Arising from the representations made by Salford to the Government Departments concerned with Consumer Protection, pointing out the hazards involved in using frying pans coated with a lead-containing tin, quite a satisfactory position has now been reached. The Home Office has informed the necessary trade associations of their view that pure tin should be used on these pans and are seeking the voluntary co-operation of all manufacturers of this type of product rather than make regulations prescribing safety requirements.

Bird Seed: It was thought that this might have been responsible for the death of cage birds but no insecticides or other deleterious ingredient could be found.

Atmospheric Dusts: Several of these were examined during the year, either to determine the particle size or ascertain the nature of the dust.

Soap: Alleged to have caused enamel attack in a bath but the allegation was unfounded.

Salmon: Contained fragments of what was thought to be broken glass but were in fact crystals of naturally occuring Struvite which are occasionally found in canned fish.

Scrapings from side of swimming bath: Found to consist of algal growth and calcium salts.

Bread from Weights and Measures Inspector: Submitted to determine whether or not the enrichment was sufficient to exempt it from the weight requirement fixed by the Bread Order, 1953.

ATMOSPHERIC POLLUTION

The National Survey of Air Pollution is being carried out by many local authorities in collaboration with Warren Spring Laboratory of the Department of Scientific and Industrial Research. In the Survey, smoke and sulphur dioxide pollutants are measured daily by a standardised procedure in which a known volume of air is drawn through a filtering device to remove smoke particles and then bubbled through a liquid to

absorb sulphur dioxide. By evaluating the depth of stain formed on the filter and the degree of acidity produced in the absorbent, the concentrations of these pollutants can be determined in the atmosphere. Five of these instruments are placed at selected sites in the City.

The results obtained during 1963 are given in Tables 4 and 5. Once again, it is a pleasure to note the overall reduction, particularly in smoke pollution.

Table 6 refers to the Smoke/Sulphur dioxide ratio. This is a very useful figure when studying pollution results and attempting to follow changes caused by the introduction of smoke control areas. In industrial areas, or where central heating is the chief source of pollution, sulphur dioxide emission will be relatively high and the ratio will be low, whereas in residential areas where smoke predominates the ratio will be high. With the introduction of smoke control areas, smoke pollution will grow less; the sulphur dioxide should also be reduced but to a smaller extent. Consequently the ratio should fall as the reduction of smoke outpaces that of sulphur dioxide.

Cleveland House is the only site in Salford surrounded by smoke control areas, and it can be seen from Table 6 that since the first of these areas became operative towards the end of 1961, there has been a greater fall in the Smoke/Sulphur dioxide ratio at this site than the others, which are not in smoke control areas.

Each month the smoke stains from Regent Road or Police Street are examined for the presence of certain hydrocarbons which possess carcinogenic properties. The results for these are given in Table 7.

TABLE 4

Smoke Pollution – Daily Averages

Results expressed as micrograms per cubic metre of air

Month	*Site*				
	Regent Road	*Cleveland House*	*Police Street*	*Murray Street*	*Encombe Place*
1963					
January	683	775	777	713	722
February	539	–	499	441	466
March	479	346	363	254	293
April	382	217	314	268	242
May	302	108	218	152	131
June	214	87	156	116	86
July	277	104	203	149	62
August	233	57	184	132	83
September	399	182	290	238	162
October	462	162	295	252	128
November	467	273	395	365	362
December	616	390	532	520	591
Daily Average for the whole year	421	246	356	300	278

Overall average – 1963 = 320
1962 = 377
1961 = 402

TABLE 5

Sulphur Dioxide Pollution – Daily Averages

Results expressed as microgrammes per cubic metre of air

Month	*Site*				
	Regent Road	*Cleveland House*	*Police Street*	*Murray Street*	*Encombe Place*
1963					
January	909	650	942	802	915
February	570	–	545	510	557
March	413	244	337	299	401
April	355	145	282	229	296
May	277	114	201	158	220
June	217	115	165	128	196
July	249	116	202	137	192
August	204	58	154	122	171
September	390	156	295	226	182
October	293	113	369	196	95
November	352	183	369	380	345
December	391	190	560	449	430
Daily average for the whole year	385	189	358	303	333

Overall average – 1963 = 312
1962 = 331
1961 = 328

TABLE 6

Yearly Smoke/Sulphur Dioxide Ratios

Year	*Site*				
	Regent Road	*Cleveland House*	*Police Street*	*Murray Street*	*Encombe Place*
1961	1.16	1.94	1.46	1.14	0.91
1962	1.17	1.55	1.11	1.11	0.93
1963	1.10	1.30	1.00	0.99	0.84

TABLE 7

Carcinogenic Hydrocarbons in the Atmosphere

Month	Micrograms smoke per 100 cubic metres	Micrograms Hydrocarbon per 100 cubic metres of Air			Parts per Million Hydrocarbons in smoke		
		Pyrene	Coronene	3.4 Benzpyrene plus 1.12 Benzperylene	Pyrene	Coronene	3.4 Benzpyrene plus 1.12 Benzperylene
1963							
January	68,300	12.50	6.11	17.34	183	89	254
February	54,000	1.38	1.32	7.02	26	24	130
March	48,000	1.11	0.82	10.68	23	17	222
April	38,200	1.40	0.82	11.85	37	21	310
May	30,200	0.63	1.21	4.95	21	40	164
June	21,400	0.79	1.51	5.07	37	71	237
July	27,700	3.21	1.23	2.63	116	44	95
August	23,900	0.59	0.11	2.38	25	5	100
September	37,750	0.91	0.44	6.15	24	12	163
October	29,500	1.39	1.92	3.33	47	65	113
November	46,750	0.79	1.21	7.87	17	26	168
December	61,700	4.06	1.38	8.70	66	22	141

SAMPLES FROM NEIGHBOURING AUTHORITIES

The City Analyst also acts as Public Analyst for the Boroughs of Eccles, Stretford and Sale. During the year the following samples were examined for these Boroughs:

Eccles: 133 Food and Drug Samples, 28 Swimming bath waters and 1 miscellaneous sample.

Stretford: 105 Food and Drug Samples.

Sale: 88 Food and Drug Samples and 3 miscellaneous samples.

Fees totalling £866 have been received by the City Treasurer in respect of this work.

DOMICILIARY MIDWIFERY SERVICE

The work under this service is becoming increasingly varied and therefore in some ways more interesting. It is felt that personal knowledge of the mother and her family and continuity of care is of great importance and for this reason it is hoped to control unjustifiable early discharges from hospitals.

The general practitioners are gradually taking more responsibility for the ante-natal and post-natal care. Several doctors have special sessions for pregnant mothers, and where invited, midwives are allocated to these doctors' sessions. This is proving an excellent arrangement and the liaison between doctor and midwife is made much more practical and possible. The mother meets both doctor and midwife at the same time and has therefore to attend one clinic only.

PARENTCRAFT

Regular courses continue covering a period of nine weeks. The courses are held at Jutland House, but mothers from all areas are invited.

Encouragement to attend is given mainly to parents expecting their first baby and the register shows that 75% of all attenders are husband and wife.

This is encouraging to the sisters of Jutland House, who give much time, energy and ingenuity to make these courses attractive and useful.

STATUTORY SUPERVISION OF MIDWIVES (Midwives' Act, 1951)

Notification of Intention to Practise

In accordance with the provision of the above Act, the number of midwives who notified their intention to practise in the area was as follows:–

(a) Institutional	53
(b) Domiciliary	31
(c) Private Practice	2
Total	86

Compulsory Post-Graduate Courses

In accordance with the rules of the Central Midwives Board, midwives have continued to attend, at least once in every five years, courses arranged for post-graduate instruction.

Attendance by Salford Midwives 1963

(a) Institutional	5
(b) Domiciliary	3
(c) Supervisor	1

Miscellaneous Notifications
(as required by the rules of the Central Midwives Board)

Notification	Domiciliary	Private Practice	Total
Stillbirth	12	0	12
Death of Mother or Baby	2 (baby)	0	2
Laying-out of dead body	8	0	8
Infection	12	0	12
Medical Aid	1,181	0	1,181

STAFF POSITION (DECEMBER 31st)

	Establishment	1963	1962	1961
Supervisor and Tutor	1	1	1	1
Assistant Supervisor	1	1	1	1
Approved District Teachers	5	3	4	3
Midwives	20	17	17	14
Part-time Midwives	—	3	2	4
Breast Feeding Sisters	2	2	2	2
Premature Baby Nurses	3	3	3	3

STATISTICS

(1) Clinics

(a) Attendances: Statistics relating to ante-natal clinic attendances will be found under "Care of Mothers and Young Children"

(b) Bookings:	Total number of domiciliary bookings	1,590	(1,692)
	Total number of Cancellations (including removals, transfers to hospital, etc.)	462	(446)

(2) Home Visiting

(a) Follow-up of clinic defaulters (b) Routine home visits	10,200	(10,604)
(c) Investigations of home conditions		
Actual homes	398	(473)
Number of visits	2,179	(1,760)

COMPARATIVE STATISTICS – HOME INVESTIGATION

Year	1963	1962	1961	1960	1959
Totals	398	478	264	247	222

Births

(1) Statistics

Doctor booked and present at delivery	19
Doctor booked, not present at delivery	1,01
Doctor not booked and present at delivery	
Doctor not booked and not present at delivery	1
	1,23

N.B.	(a) 4 cases of twins occurred, making Total number of births	1,23
	(b) Average number of cases per midwife	7
	(c) Domiciliary births formed (of total Salford births)	58

COMPARATIVE STATISTICS

Year	Live Births	Stillbirths	Total
1959	1,181	12	1,193
1960	1,197	10	1,207
1961	1,241	7	1,248
1962	1,341	8	1,349
1963	1,222	12	1,234

Number of nursing visits following delivery	20,83
Number of nursing visits for hospital discharges	4,47
Total	25,30

(2) Analgesia

	Number of Mothers
Nitrous Oxide	1
Trilene	917
Pethidine	804
Total inhalation analgesia	918 i.e. 75% of all births

(3) Stillbirths

Comparative Statistics	Number of Stillbirths	Rate per 1,000 Registered Births
1959	12	10.0
1960	10	8.3
1961	7	5.83
1962	8	6.0
1963	12	9.9

SUMMARY OF CASES

Classification		Presentation	Weight lbs	Weight ozs	Gestation approx.	Condition	Contributory Factors
Ante-partum Anoxia	1	?	5	12	36 weeks	Macerated	No ante-natal care – B.B.A.
	2	Vertex	8	4	40 weeks	Early Maceration	Intra-uterine death during last week of pregnancy. Spalding's sign.
	3	Vertex	7	15	42 weeks	Early Maceration	No foetal heart at onset of labour
	4	Vertex	4	8	36 weeks	Macerated	Death 1 week before labour.
Intra-Partum Anoxia	1	Vertex	11	–	?43 weeks	Fresh	Impacted shoulders
	2	Vertex	8	–	?42 weeks	Fresh	Rh. negative. No antibodies.
	3	Vertex	6	13	41 weeks	Fresh	No obvious abnormality.
Foetal Abnormalities	1	Breech	3	–	30 weeks	Macerated	Gross abnormalities.
	2	Vertex	6	13	38 weeks	Macerated	Hydrocephalus. Rh. – No antibodies.
	3	?	8	–	40 weeks	Fresh	Hydrocephalus. Para VIII B.B.A.
	4	Vertex	6	8	?36 weeks	Fresh	Spina Bifida.
	5	Breech	2	–	?28 weeks	Macerated	Small abnormal Foetus.

Drugs were not found to be the cause of abnormality in any of these cases.

(4) Neo-natal Mortality (born and died at home)

Prematurity	3
Pneumonia	1
Intracranial Haemorrhage and Breech Delivery	1
Cerebral Haemorrhage and Prematurity	2
Intra-uterine Aspiration Pneumonia	1
Cerebral Haemorrhage	1
Total	9

(5) Emergency Obstetrical Unit

The Emergency Obstetrical Unit, operating from Hope Hospital, wa called out on 12 occasions during the year.

SUMMARY OF CAUSES

Post-Partum Haemorrhage	10 times 8 of these mothers were subsequently admitted to hospital.
Ante-Partum Haemorrhage	1 admitted to hospital.
Abnormal Presentations	1 admitted to hospital.

(6) Puerperium

Infection

	Hospital	District	Total
Puerperal Pyrexia	31	4	35
Ophthalmia Neonatorum	0	1	1
Pemphigus Neonatorum	0	0	0

Causes of Pyrexia were as follows:—

	Hospital	District	Total
Uterine Infection	6	1	7
Respiratory Infection	6	2	8
Urinary Infection	15	0	15
Breast Infection	2	0	2
Undiagnosed	2	1	3

OPHTHALMIA NEONATORUM

One case was notified during the year which was of gonococcal origin

BREAST FEEDING SERVICE

The two sisters continue to attend ante-natal clinics, discuss feeding of the new baby from all aspects and hold preparation classes for those wishing to breast feed.

More and more their work is in the mother's home after delivery and continuity of advice is thus maintained. The sisters work in close liaison with the general practitioner, hospital, midwives and health visitors.

One sister was called upon at a Post-Graduate Course to open a discussion on this service, one which is certainly appreciated by the mothers of Salford.

PREMATURE BABY SERVICE

The three nurses of the service made 1,649 visits during the last year and the number discharged from hospitals and requiring their care continues to increase.

Many social problems arise among this group of mothers who tend to be in the lower income group and mothers with large families. It is notable how recurrent prematurity is in this group and how well known some families have become to the sisters of the service.

A special check continues to be kept for the first year after birth by the Consultant Paediatrician and Health Department staff.

SALFORD PART II MIDWIFERY TRAINING SCHOOL

One-third of the babies born at home in Salford are delivered by the nurses in training at our school. Most nurses undergoing Part II training are State Registered general nurses with a minimum of six months hospital midwifery experience. The purpose of the second period of training is to widen the nurse's knowledge of Health Services as a whole, to help her to understand the problems of families living in an industrial area and give her confidence in her own decisions as a midwife.

The teaching midwives attached to the school play an integral part in this practical training and they have also been encouraged to further their own theoretical knowledge and thus increase the value of discussions with their students. One member has been successful in obtaining the Midwife Teacher's Diploma, a second has been successful in Part I of the course, while a third has undergone the training course and is due to take the examinations in the near future.

28 pupils completed their training during the year and 25 were known to take midwifery posts in some capacity immediately after qualifying.

SOCIAL ACTIVITIES

These are limited in the precincts of Trafford Road; however social evenings are held and small efforts have helped to provide funds for expenses. On 23rd December a Christmas Dinner was provided by the Health Committee for the pupil-midwives. They were attended by the Teaching and Administrative Staff, after which friends and other visitors were entertained by the complete staff to a special interpretation of "The Christmas Story."

CARE OF MOTHERS AND YOUNG CHILDREN

STATISTICS

The figures in this section are compiled locally and do not necessarily correspond with those compiled by the Registrar General.

BIRTHS

We received 4,047 live birth notifications and 93 stillbirth notifications in total in respect of 1963; after adjustment by transfer-out of births in the City relating to outside residents, 3,180 live births and 71 stillbirths were classed as Salford births. These figures, set against the Registrar General's mid-1963 estimated population for the City, gave a Live Birth Rate of 20.88 and a Stillbirth Rate of 21.8.

Institutional births to Salford mothers accounted for 62.2% of the births which is just over 3% higher than last year, but still not as high as the proportion recommended in the Cranbrook Report.

INFANT DEATHS

There were 71 stillbirths and 98 infant deaths during 1963.

The stillbirth rate was 21.8 per 1,000 registered births and the infant death rate was 30.81 per 1,000 live births.

As is found in all statistics relating to infant deaths, the early days of life are associated with the greatest hazards. The following table shows that more than one-third (38) of the infant deaths occur in the first 24 hours of life, that more than half (57) occur in the first week of life and almost two-thirds (63) of the total infant loss occur in the first four weeks of life.

Stillbirths	71	128 — Peri-natal Death Rate 39.37	57 Early Neo-Natal Deaths — Death Rate 17.92	63 Neo-Natal Deaths — Death Rate 19.81
Deaths under 24 hours	38			
,, 1 — 6 days	19			
,, 2 — 3 weeks	2			
,, 3 — 4 weeks	4			
,, 1 — 6 months	28			
,, 7 — 11 months	7			

98 Infant Deaths — Death Rate 30.81

The causes of infant deaths in numerical order are:—

1.	Prematurity	35
2.	Respiratory diseases	30
3.	Congenital defects	13
4.	Other causes	11
5.	Birth injury	7
6.	Gastro-enteritis	1
7.	Accidental death	1

Causes and Age at Death	Under 24 hours	1–6 days	2–4 weeks	1–6 months	7–11 months	Total
Prematurity	24	9	2	–	–	35
Congenital Debility	–	–	–	–	–	–
Congenital Defect	5	–	4	4	–	13
Birth Injuries	3	4	–	–	–	7
Respiratory Diseases	4	3	–	20	3	30
Other Causes	2	3	–	3	3	11
Gastro Enteritis	–	–	–	1	–	1
Accidental Deaths	–	–	–	–	1	1
Total	38	19	6	28	7	98

Salford Deaths	77
Transferred-in-Deaths	21

As can be seen from the table, all deaths due to prematurity and birth injury and two-thirds of the deaths due to congenital abnormalities occur in the first month of life. These three aspects of neonatal mortality and the causes of stillbirth which are closely associated with the causes of infant death in the early days of life have received a great deal of interest and attention from research workers in both the United Kingdom and the rest of the world. Work is continuing, but until the causes of prematurity and congenital abnormality can be ascertained with a greater degree of accuracy than we are able to do at present, infant deaths due to these causes will unfortunately continue.

We are still afflicted with the curse of respiratory disease and this curse is apparent even in our little children. As the table shows quite clearly almost one-third (30) of the infant deaths are due to respiratory diseases.

The importance of respiratory disease as a child-killer can be further realised when one sees that 23 of the deaths in the one to 11 months age group, out of a total loss of 35, are due to this cause. It is interesting to note that 12 wards of the City each had either one or two infant deaths due to repiratory diseases. Two wards of the City – Weaste and Seedley – had no infant deaths due to this cause, but St. Paul's had five deaths due to this cause and Ordsall Park had six deaths.

DEATHS 1–5 YEARS

There were 19 deaths in this age group during 1963 and the most important single cause of death is respiratory disease, which caused the death of seven children. There were three accidental deaths all due to road accidents, one death due to gastro-enteritis and eight deaths in the group "other causes": of the deaths in this class two were due to leukaemia and two were due to encephalitis.

Cause of Death	Aged 1 year	Aged 2 years	Aged 3 years	Aged 4 years	Total
Respiratory Disease	5	2	–	–	7
Accidental	2	–	1	–	3
Gastro-entiritis	–	1	–	–	1
Other Causes	3	2	1	2	8
Total	10	5	2	2	19

As in the infants, respiratory disease plays a major role in the mortality of young children, particularly during the second year of life and no effort must be spared in searching out and eradicating the causes of respiratory disease. Not only will this be of inestimable value to children, many as yet unborn, but it will be of the greatest value to adults and old people.

Road accidents have assumed a tragic significance in the figures for 1963 and we must remind every motorist of the Ministry of Transport's slogan "Mind that Child." There is no sight more terrible than that of a bloodstained child lying dead in the road.

MATERNAL DEATHS

There were three deaths due to or associated with pregnancy, childbirth or abortion during 1963. This gives a maternal mortality rate of 0.92 per 1,000 registered births.

The number of maternal deaths is compared with none in 1959, none in 1960, none in 1961 and two in 1962.

Of the deaths which occurred, two were due to pulmonary embolism occurring after the delivery of the infant. The first case occurred shortly after delivery by caesarian section and the second case occurred in hospital on the twelfth day after an apparently normal home confinement. Both patients' notes have been examined by a consultant obstetrician and he classified the deaths as "unavoidable." It is particularly tragic that in these two cases, young families were left motherless.

The third death was due to septic abortion and as a result of police investigations, a defendant was convicted of using an instrument to procure abortion. This death was unfortunately avoidable in so far as the mother, an unmarried woman, submitted herself to the attentions of an abortionist and did not reveal this to her medical attendants.

In all three cases the deaths occurred in hospital where everything possible was done to save the patients' lives.

ANTE-NATAL CLINICS

Every effort has been made this year to streamline the running of these clinics so that waiting time for the mother is reduced to the minimum. In this respect the appointment system which is in operation at all the ante-natal clinics is successful. Unfortunately, there are occasionally a few mothers who do not keep their appointments and this can be a nuisance at the busier clinics.

The tabulation on the next page shows the distribution of work between the various clinics, together with the totals for 1962 for purposes of comparison.

Clinic	Number of sessions weekly	Total individuals attended clinic	Total attendances	Consultations By Local Authority Medical Officers	Consultations By General Practitioners employed on a sessional basis	New attenders
Encombe	1	127	737	173	4	90
Kersal	1	175	944	199	43	126
Langworthy	2	453	2,517	553	–	361
Murray Street	2	531	2,497	639	63	449
Ordsall	1	189	1,111	219	–	149
Police Street	1	154	797	205	–	118
Regent	1	249	1,254	287	–	202
Summerville	1	149	900	–	183	107
Total	10	2,027	10,757	2,275	293	1,602
Totals 1962	10	2,297	12,071	3,010		1,806

From these statistics we see that 270 fewer mothers attended this year than in the previous year and there is a corresponding fall of 1,314 when the figures for total attendances at the clinics in 1962 and 1963 are compared. There is also a fall in the number of new patients from 1,806 in 1962 to 1,602 in 1963. This is not due to a fall in the birthrate, nor to a fall in the number of home confinements: it is partly due to the increasing number of mothers who attend Hope Hospital for ante-natal care and admission for delivery only and partly due to the increasing number of general practitioners who now hold ante-natal clinics for their own booked patients at their own surgeries. At these clinics a local authority midwife is in attendance and a standard of ante-natal care as high as that at the local authority clinics, is maintained. The patients of the doctors concerned are very appreciative of this new development as it reduces the number of appointments they have to make, to see doctor and midwife separately, without diminishing in any way the quality of ante-natal care which is their right.

General practitioners employed by the local authority on a sessional basis attended a small proportion of the local authority ante-natal sessions and gave 293 consultations. Local authority medical officers gave 2,275 ante-natal consultations.

All mothers who attend the local authority ante-natal clinic are given an appointment to be examined by the clinic doctor at the earliest opportunity. Each mother is given a complete medical examination by the doctor and the necessary blood samples are taken. At subsequent visits the patient is examined by the midwife and at the 32nd week of pregnancy a further blood specimen is taken by the doctor. At every visit to the ante-natal clinic the mother is weighed, her blood pressure is taken, and a specimen of urine is examined.

The number of blood tests taken at the ante-natal clinics were as follows:–

(1) Wasserman P.P.R. and R.P.C.F. tests 1,343 of which six gave a positive result.

(2) Haemoglobin tests 2,167.

(3) Rhesus factor 1,287.

In all cases the results were communicated to the family doctor by letter so that any necessary investigations or treatment could be carried out.

In addition to the routine blood tests carried out at the ante-natal clinics, 282 mothers attended the Rhesus investigation clinic which is held at Regent Road Clinic and 211 were found to be Rhesus negative. A second test at 34 weeks was carried out on the Rhesus negative mothers in order to detect antibodies, with the following results :–

7 mothers were found to have Anti D antibodies,

1 mother was found to have Anti D and C antibodies,

1 mother was found to have Anti D and P antibodies,

2 mothers were found to have Anti OH antibodies,

1 mother was found to have Anti OH and La antibodies.

Of the nine mothers with Anti D antibodies –

3 had normal healthy infants,

1 infant was born with haemolytic disease,

1 infant was born with jaundice,

1 infant was born prematurely with a severe degree of anaemia,

1 infant was born prematurely and died at 17 hours, the registered cause of death being haemolytic disease of the newborn,

2 infants were unborn at the time of writing.

POST-NATAL CLINICS

During 1963 only one post-natal examination was carried out at a local authority clinic. Over the years the amount of work in this field has diminished almost to the point of non-existence as the onus of doing a post-natal examination now falls on the general practitioner who has been booked to attend the patient during her pregnancy and confinement. In Salford it is the practice to insist that every woman booking a midwife for a domiciliary confinement also books a general practitioner, and consequently it is only those mothers who do not get in touch with a midwife until they are actually in labour who are not booked with a doctor. In 1963 there were only 18 such cases and none of those mothers attended a local authority clinic for her post-natal examination. This is not surprising as the women who make no effort to obtain ante-natal care are now almost entirely confined to the itinerant and vagrant section of the community.

CHILD WELFARE CLINICS

Child welfare clinics record fewer individuals attending and fewer total attendances than in 1962. This is in part due to the increased interest in preventive medicine shown by general practitioners, reaching expression as baby clinics held at the general practitioners own surgeries. Another factor is the smallpox epidemic of 1962 which resulted in very large attendances at the clinics for smallpox vaccination, thereby greatly reducing the number of children in need of smallpox vaccination (which the Ministry of Health recommends should be carried out in the second year of life) during 1963.

The tabulation below shows the distribution of the work throughout the clinics; the figures in brackets relate to 1962:–

Child Welfare Clinic Sessions

Clinic	Weekly Sessions	Attendances	Individuals	New Cases	Consultations	Referrals
Cleveland	2	2,739 (2,880)	386 (401)	188 (161)	442 (462)	30
Encombe	1	1,279 (1,607)	277 (320)	146 (157)	262 (274)	19
Kersal	2	2,521 (2,052)	337 (364)	162 (155)	325 (371)	30
Langworthy	4	8,286 (9,471)	1,368(1,773)	637 (666)	1,617(1,731)	127
Murray St.	3	6,192 (7,699)	1,256(1,631)	732 (714)	1,035(1,747)	121
Ordsall	2	2,286 (2,336)	409 (445)	212 (171)	497 (506)	44
Police St.	3	3,017 (4,553)	565 (849)	212 (316)	586 (871)	43
Regent	3	3,538 (3,488)	659 (827)	351 (279)	556 (742)	62
Summerville	2	2,556 (2,731)	321 (375)	141 (129)	313 (385)	34
Premature Baby (*Plus 51 who have also attended other C.W.C.)	1	161 (205)	18* (30)	31 (35)	145 (200)	1
Totals	23	32,575(37,022)	5,596(7,015)	2,812(2,783)	5,778(7,289)	511
Removed out in 1963		–	293 (353)	–	–	–
Clinic children died in 1963		–	7 (14)	–	–	–
Attended and became 5 years in 1963		–	89 (304)	–	–	–
Grand Totals 1963		32,575(37,022)	5,985(7,686)	2,812(2,783)	5,778(7,289)	511
Grand Totals 1962		37,022	7,686	2,783	7,289	–

*69 Individual children attended Premature Baby Clinic, but only 18 had not attended other clinics.

The work carried out at the clinics has followed the normal pattern, i.e. medical examination by local authority doctors, weighing and advising by the nursing staff, and immunisation, vaccination and education in all aspects of child care by all members of the staff. In spite of the fall in total attendances, the number of new cases shows an increase from 2,783 in 1962 to 2,812 in 1963.

The new clinic at Kersal which opened in February, 1962, is now well established, but Police Street Clinic is less busy because a large part of the area it serves has been demolished and although rebuilding has started, none of the dwellings are habitable as yet.

Approximately three-fifths of the sessions during the year were held by medical staff; general practitioners employed on a sessional basis conducted 25% of these sessions; the remaining two-fifths sessions were held by health visitors.

Consultations have been fewer this year due to the shortage of medical staff and the need to spread the services of those available to cover as many facets of public health work as possible.

Referrals for Further Advice or Treatment, Consultant Sessions, Hospital Liaison.

As will be seen from the above tabulation approximately 10% of all consultations necessitated further advice or treatment and 25% of such referrals were to consultants holding sessions on local authority premises; other referrals were for dental treatment, physiotherapy treatment and various other matters not requiring the advice of these consultants.

One half of the children referred for further advice or treatment were in the 2–5 year age group. One quarter of all attendances in this age group resulted in consultation with the doctor and 25% of the children seen by the doctor were referred elsewhere. This is not surprising as one finds that the older children usually attend the child welfare clinics only when the mother thinks there is something amiss or when she can be persuaded by the health visitor that some form of treatment may be necessary.

Consultations with the doctor in the 1–2 year old group were 14% of the clinic attendance for that age group and one-sixth of the children seen by the doctor were referred for further advice.

The medical staff dealt with 19% of all attendances in the 0–1 year age group and 4% of these children were referred by the doctor for further advice.

It is a matter of great concern that children in the 2–5 year age group only attend the clinic when something appears to be going wrong. We would welcome more frequent attendances from these children as it would enable the staff to detect defects at an earlier stage and to advise the parents on the treatment of these defects. There is no doubt that greater attention to the pre-school child would result in a healthier school child with less sickness absence and we also hope to achieve a smaller proportion of "unsatisfactory" children than we are experiencing at the present school entrants routine medical inspection.

Consultant clinics were – on the whole – busier this year; paediatric and orthopaedic referrals were twice as heavy as the previous year and much higher attendances were recorded. A slight increase was shown in ear, nose and throat referrals with consequent higher attendances; perhaps parents are less concerned with defects dealt with at this clinic and maybe regard such

complaints as normal for the area and the climatic conditions prevailing. The premature baby clinic was slightly less busy this year.

Letters from hospitals concerning in-patients or out-patients discharged were 300 more this year (1,628 such letters were received); all letters are perused by medical and nursing staff, acted upon where necessary and then filed with the local authority case notes for the child concerned.

Age Groups Statistics

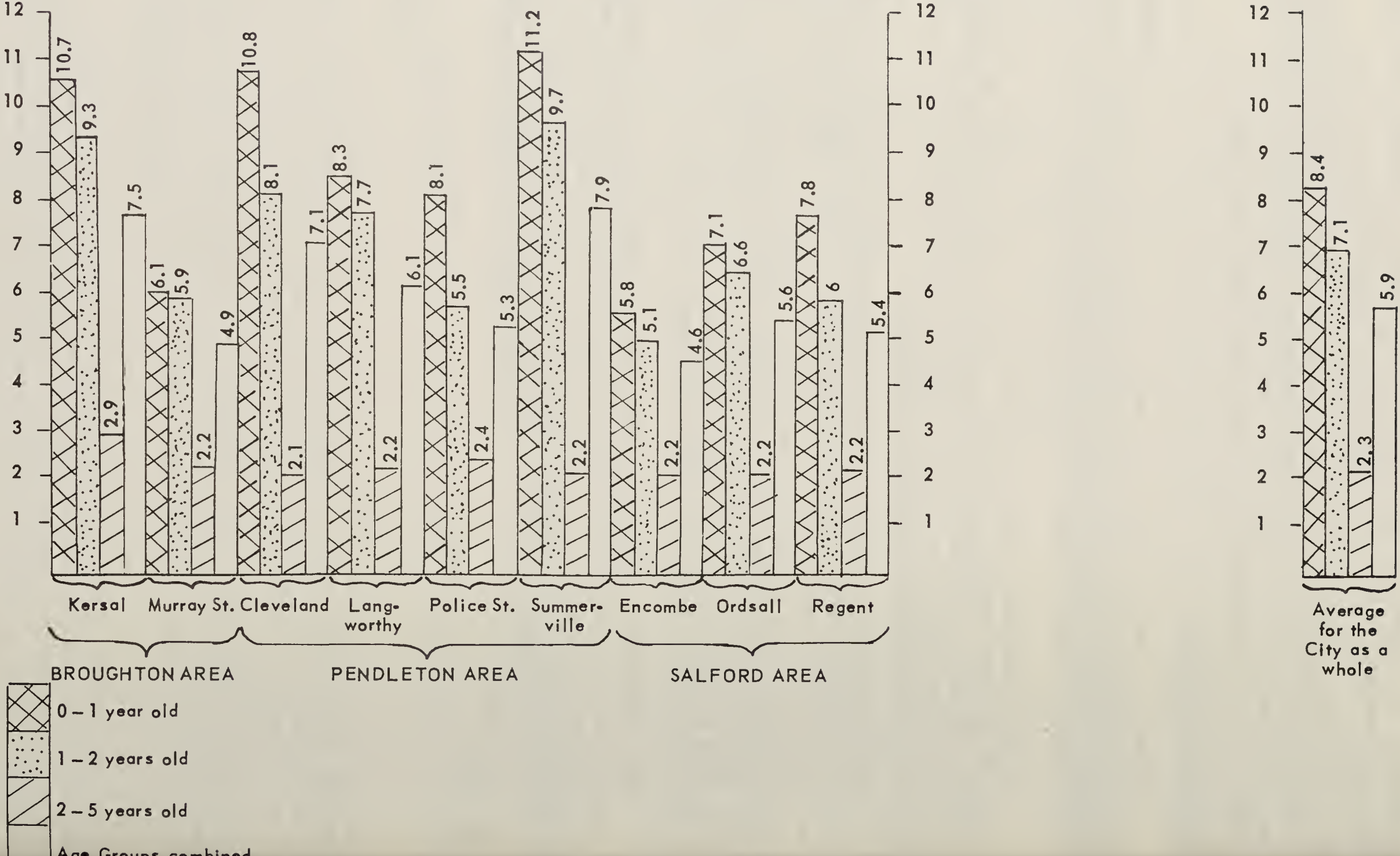
Migration is still a problem and much work is carried out in assembling and forwarding records to other areas and receiving similar records regarding children who have moved into Salford. The important transfer of records from Child Welfare to School Health Service was still maintained.

At 31st December, 1963, we estimated that 13,496 children under five years of age were residing in the City – this is 150 more than the previous year and is due to removals in to the City rather than to an increase in the number of births; there were, however, 200 fewer children in the 2–5 age group at 31st December than at the previous year-end.

The collation of statistical data is a little different this year in accordance with Ministry requirements so that comparison of age group attendances for former years is not possible. The 0–1 and 1–2 age groups show little change, i.e. 3,008 and 2,813 respectively with clinic attendance of at least once by two-thirds of the 0–1 group and three-quarters of the 1–2 group; the 2–5 group was estimated to be 7.675 at the year end only 25% attended a clinic compared with 50% in 1962 but it was felt that this was due to lack of demand for vaccination against smallpox at clinic sessions.

The interesting tabulation on the following page shows the pattern of attendances in all clinics in all age groups concerned, together with average attendances for the City as a whole. As will be seen, Cleveland, Kersal and Summerville record more average attendances per child under one year of age and Kersal and Summerville record more than average attendances in the 1–2 age group; attendances in the 2–5 age group appear to be similar throughout the City.

AVERAGE ATTENDANCE PER CHILD AT CHILD WELFARE CLINICS



WELFARE AND PROPRIETARY BRAND FOOD SALES

Again we have to report a downward trend in sales of National Dried Milk and an upward trend in sales of Proprietary Brands; sales of evaporated milks have increased a little this year.

The wide variety of cereals stocked is greatly appreciated by the clinic users and the introduction of the sale of rusks has been very popular; there has been a steady demand for the propietary milk foods containing vitamins, etc.

Products containing vitamin supplements have sold well over the year and the newer type products have proved to be popular at the expense of old-tried favourites; proprietary Vitamin C Liquids are especially popular, no doubt because of their ease in preparation and administration.

For the first time since the introduction of the economic price for Orange Juice the sales have been higher: 2,000 more bottles were sold in 1963 than in the previous year, giving an estimated uptake of 6.9% (.2% more than in 1962); Cod Liver Oil sales show a decrease in sales with an estimated uptake of 2.9% (.4% less than sales for 1962). There is a very slight downward trend in sales of Vitamin A/D Tablets during the year with an uptake estimated to be 16.25% for the year (.55% less than 1962 uptake).

Every opportunity is afforded to mothers to purchase National Welfare Foods: 39 selling sessions are held weekly at various points within the City and we are once more indebted to the W.V.S. for their assistance in maintaining sales at the Hope Hospital distribution point.

VISITS TO VOLUNTARY ORGANISATION MOTHER AND BABY HOMES

There are two Voluntary Mother and Baby Homes in Salford, namely St. Teresa's Home which is run by the Sisters of Charity of the Society of St. Vincent de Paul, and Adswood which is run by the Salvation Army.

As in previous years both homes were visited by the Senior Assistant Medical Officer for Maternity and Child Welfare and conditions for the care of mothers and babies are satisfactory. Extensions have been carried out at Adswood and extensions to St. Teresa's Convent are in the planning stage.

In the latter half of the year the staff of St. Teresa's Home co-operated with the staff of the Health Department in field trials with an improved variety of infant food and although the work involved some inconvenience for the nuns, their co-operation was most generous and greatly appreciated.

DENTAL CARE

Arrangements for the dental treatment of expectant and nursing mothers and pre-school children were continued as in previous years, i.e., treatment was given on referral by the doctors, health visitors, etc., and no system of routine examination was carried out. This treatment was integrated with the normal work of the school clinics and was not carried out during specific sessions set aside for the purpose.

All forms of dental treatment were available. Dentures, when supplied

were fabricated under private contract with outside laboratories.

Dental Services for Expectant and Nursing Mothers and Children Under School Age

Part A. Dental Treatment — Number of Cases

		Number of Persons examined during the year (1)	Number of Persons who commenced treatment during the year (2)	Number of courses of treatment completed during the year* (3)
1.	Expectant and nursing mothers	143	123	91
2.	Children aged under 5 and not eligible for school dental service	476	395	362

*If a patient has had more than one course of treatment during the year, each cours is counted.

Part B. Dental Treatment Provided

		Scalings and gum treatment (1)	Fillings (2)	Silver nitrate treatment (3)	Crowns and inlays (4)	Extrac-tions (5)	General anaes-thetics (6)	Dentures provided: Full upper or lower (7)	Dentures provided: Partial upper or lower (8)	Radio-graphs (9)
1.	Expectant and and nursing mothers	4	38	—	—	132	34	14	8	—
2.	Children aged under 5 years and not eligible for school dental service	—	73	170	—	521	234	—	—	—

Note. Figures refer to number of treatments and not to number of persons

Part C. Number of Premises and Sessions

1.	Number of dental treatment centres in use at end of year for services shown in Part B above	5
2.	Number of dental officer sessions (i.e. equivalent complete half days) devoted to maternity and child welfare patients during the year	35

PHYSIOTHERAPY SERVICE

During the year the physiotherapist have done their best to give service where the need has been greatest and to use the small number of physiother-

apists to the greatest advantage. There has been a 50% staff shortage throughout the year and at some periods less than this percentage has been available. As usual we have been very glad to have the help of part-time married physiotherapists, two of whom have during the year had babies of their own and have naturally been away from the clinics for a considerable time.

It is found at the clinics that the amount of work tends to fluctuate at different times and it is better to be adaptable in planning the time-table. When a department is very short staffed it is better to make extra physiotherapy sessions available where the greatest amount of work is waiting and to cut down on sessions during quiet periods.

Day nurseries present a problem; the majority of children are admitted to the nurseries either because their mothers are working full-time, or because there are special home difficulties. Children whom the medical officers refer for treatment practically never attend a clinic when invited and never have any treatment unless the physiotherapist can visit the nursery, which unfortunately requires a large amount of the physiotherapist's time.

Several young married physiotherapists are very interested in teaching the mothers at ante-natal relaxation classes, but the response from the mothers varies very much at the different clinics. In some areas the mothers are co-operative and willing to learn all they can to help themselves and their babies; whereas in other areas where possibly the need for relaxation is greater there is no co-operation from the mothers.

The teaching of correct methods of breathing, posture and relaxation would be of great value in mental health work amongst the young adults attending the training centre, but unfortunately this part of our work has been very neglected this year. If it is possible to start again in the future there will be much interesting work to be done in the centres exploring what contribution physiotherapy can make towards helping those who attend to have a fuller enjoyment of life.

At Wilmur Avenue Special Care Unit we have tried to maintain treatment throughout the year. Nothing like as many treatment sessions are held there as should be, and a great deal of work is always waiting. There are a number of cerebral palsied children attending the centre who would benefit from more treatment than they are at present receiving.

We are fortunate that the orthopaedic consultant is always ready to visit any of the centres and advise on treatment and any form of appliances that may be of help.

The physiotherapy clinics held at Langworthy in connection with the medical officers' geriatric clinic are very much appreciated and could be filled many times over and certainly the attendance record is the highest of any of our clinics. So many old people are lonely living on their own that it is a welcome break to have some definite appointment one or two days of the week. As well as the benefit from treatment there is the psychological uplift of a chat and a cup of tea with other people. We have a considerable waiting list with little chance of it being reduced as we rarely have a vacancy because our value is in helping the elderly to be mobile and keep active, unlike a hospital giving a short course of treatment and early discharge.

Our work is always interesting and there is so much scope for extending and improving our services to the public, not only in helping to cure disease but in prevention, and in helping people to have a greater feeling of well-being and health.

SPECIAL MEDICAL EXAMINATIONS

During the year we have co-operated with the Children Department on frequent occasions when children being taken into care required medical examinations. No records of these examinations are kept as they are usually arranged on an informal basis by telephone between the Child Care Officer concerned with the case and the Medical Officer at the most convenient clinic.

In one special case we were asked by the Children Department to examine a 17 year old girl prior to admission to a Probation Hostel in Liverpool, but the girl, who was of low mentality, absconded and consequently did not attend for examination.

In addition to this, 17 children were examined under the regulations of the Adoption Act, 1958. All the children were found to be suitable for adoption. In one case there was some doubt about the child's visual acuity, and it was arranged to re-examine the child in six months.

In 1962 adoption examinations were carried out on 13 children and in 1961 the number was nine.

CANCER CYTOLOGY CLINIC

For some time the condition of Cancer of the Cervix has been causing grave concern and it was felt that steps should be taken to find a method of early detection. A method has been devised and is now available to all women living in Salford who are between the ages of 25 and 65 years. The work is carried out by a woman doctor.

The scheme in Salford (the first County Borough to do this work) began in July, 1963, during the weeks of the Health Survey, when over 600 women asked to have this test. During the latter part of July and most of August four clinics were held weekly, but this number had to be reduced to three per week in September because with the return of the children to school the Clinics were needed for other work. It took until the end of November to work through the long list of requests. The great majority of those who were invited to the clinics for the test attended, but just over 100 defaulted for one reason or another, e.g. they had either left the district or changed their minds.

A total of 488 patients were examined up to 31st December, 1963, and of this number four were reported as "possibly early cancer". These patients were followed up and three were confirmed as early cancer, and with the co-operation of the general practitioners, treatment was arranged.

This is extremely important work because early detection can prevent years of suffering later on. These clinics have come to stay; there are two held every week and two others when the occasion merits it. All attendances are by appointment only. Women within the age group who are not Salford

residents can be seen if their general practitioner agrees.

As another common site of cancer in women is the breast, a clinical examination of the breasts is also carried out at the same time.

"HANDICAPPED" REGISTER

There are now 274 children on the handicapped register (0 to 5 years). During the year 1963, 126 names were added to the register, and 77 names were removed. In addition six names were put back on the register, having been removed previously when the families concerned moved out of Salford.

No. of names on Register in 1962	219
No. of names added to the register during 1963	126
No. of names replaced on register	6
	351
No. of names removed from the register	77
Total number of children on the register 31. 12. 63	274

The children whose names are put on the register are notified to us by health visitors and by doctors working as local authority medical officers, general practitioners or hospital doctors. The type of handicap which is noted varies from scarring following burns, to severe mental and physical retardation. The criterion for a child's name to be included on the register is whether or not he will be mentally, physically or socially handicapped by the condition. After a child's name has been added to the register, reports from health visitors are requested at regular intervals, and in many cases special home visits to ascertain his progress are made. The object is to ensure that the child receives the medical treatment which is required and that his handicap is offset by special training. In all cases the emphasis is on training the child to make the best use of his abilities and not to dwell on the disability. The most obvious example is the training of blind children to read Braille with their fingers, and to play ball games by using a ball with a bell inside it. In a less dramatic field the provision of an artificial limb gives a limbless child a feeling of "sameness" with his fellows and enables him to join in with the activities of other children. In many cases the parents of a handicapped child are so distressed by his handicap that they need help and reassurance themselves before they are able to help him to accept the disability and to overcome it.

At the age of two years the case is reviewed and if it appears that the child may need special educational treatment, the School Health Service is informed so that arrangements can be made at an appropriate age for him to be examined by a School Medical Officer with a view to arranging education in one of the special schools. It frequently occurs that a severely handicapped child needs greater contact with other children than the mother has been able to provide and we appear to be in need of facilities to this end. A limited number of handicapped children can be admitted to the Day Nurseries but the pressure on the staff of the Day Nurseries makes it impossible to admit very severely handicapped children. Greengate Special Open Air School accommodates a number of socially handicapped children but without transport facilities we are unable to admit children to this school from all parts of the City. A class for the under fives at Oaklands School would be of inestimable value for the severely physically handicapped child, and one would like to press for the early opening of such a class.

In the case of a child who appears to be mentally retarded to such a degree that education within the school system may not be possible, the Mental Health Section, as well as the School Health Section, are informed when the child reaches the age of two years. The staff of the Mental Health Service visit the child's home and make an assessment of his abilities and where it is indicated, he is admitted to Wilmur Avenue Centre, where the child and his abilities can be studied over a period of months or even years. This Centre is of particular value where a child is both mentally and physically handicapped, but unfortunately there is a waiting list for admission. This problem may be solved when the new Seedley Centre is opened.

The children's names are removed from the handicapped register when the child reaches the age of five years, on removal from the district, when the handicapping condition is cured or if the child dies. During 1963, 42 children reached the age of five years, seven children were stated to be completely cured, 21 children left the district and seven children died.

The following table gives a list of defects from which the children are suffering and the numbers of children in each category (where a child has more than one defect, he is included in the category of the principal defect).

Blind	1
Partially sighted	7
Other eye defects	—
Deaf	6
Partially hearing	5
Delicate respiratory conditions	7
,, circulatory conditions	37
,, gastro-intestinal conditions	14
,, genito-urinary conditions	8
,, miscellaneous conditions	27
Epilepsy	5
Recurring convulsions	13
Mental subnormality	48
Cerebral palsy	7
Other diseases of the nervous system	33
Orthopaedic defects	44
Cleft palate and hare lip	7
Speech defects	5
Total number of children	274

Of these 274 children, 49 have the misfortune to suffer from two or more handicaps, i.e. 35 children who are included in the category of mental retardation are also suffering from a further handicap, e.g. epilepsy, congenital heart lesion, cerebral palsy.

During the year 42 children reached the age of five years and started on their school careers as shown below:—

Ordinary school	18
Ordinary school whilst awaiting admission to partially hearing class	1

Ordinary school whilst awaiting admission to Oaklands	1	
Claremont Open Air School	6	
Parkfield	4	
Wilmur Avenue Centre	4	
Oaklands School	4	
Royal Residential School for the Deaf	1	
Notified to the Mental Health Service as being unsuitable for education in school	2	(one child attends a training centre but in the other case, the mother refuses to allow the child to attend a training centre)
No information available	1	

It is our declared intention that all children who have the misfortune to be handicapped, mentally, physically or socially, should be given every possible help and encouragement in overcoming their disability.

"AT RISK" REGISTER

During the year an "At Risk" register was started in an attempt to focus local authority services on children who for various reasons are in danger of developing handicaps both mental, physical and social. The object of the register is to keep a record of these children and to enable adequate follow-up of each individual child so that the earliest deviation from the normal pattern of growth and development can be detected and treatment started at the earliest opportunity. In fact this is not a new venture for this Health Department as certain "at risk groups" have in recent years been identified and followed up. The most well-known example of our work in this field is the case of children born to mothers with Rhesus negative blood. In certain cases children may develop deafness, or mental defect as a result of Rhesus incompatibility and all efforts are devoted to ensuring that such children are examined for hearing defect and are observed re mental development. Another example is the case of children who have had meningitis or a severe head injury. Such children are observed for a considerable length of time to ensure that any signs of hearing or mental defect are treated early.

With the advent of a formal "At Risk" register the number of children inlcuded in this category has increased and now includes all premature babies and all babies who have abnormal births or who suffer from any degree of anoxia at birth: all babies born to mothers with Rhesus negative blood with antibodies or mothers who have suffered illness or any obstetric abnormality during pregnancy. Also included on the register are children with family histories of epilepsy, diabetes mellitus, mental illness or retardation, etc., and children who have suffered from illnesses such as tubercular meningitis or head injury which predispose to defects of the brain and may give rise to deafness, deterioration of the personality or mental retardation.

Information about these children comes to us in a variety of ways, but at the moment the majority are put on the "At Risk" register following the receipt of a copy of the hospital discharge letter. Thereafter the notes made by the doctor or health visitor at Child Welfare Clinics or following home visits are

studied at regular intervals and special home visits are requested when nece
ssary.

At the present time there are 206 children on the "At Risk" register mad
up as follows:—

Children born to Rhesus negative mothers with antibodies	50
Children who had abnormal births	144
Children who have had encephalitis, tuberculosis, meningitis, fractured skull, etc.	12
Total	206

A fuller report on the "At Risk" register will be prepared at the end o
1964 when we have had more experience with it.

DAY NURSERIES

ATTENDANCES AND ADMISSIONS

There has been no change in Day Nursery accommodation during the year; the 235 places in the five Day Nurseries are allocated so that 44 children aged 6 months to 18 months are catered for; 84 children from age 18 months to 2½ years and 107 from 2½ years to 5 years. The tweenies and toddlers often play together but it is noticeable that when children from these groups visit the baby room the toddlers linger to touch the baby toys but the tweenies are anxious to return to the "higher status" of their tweenie room. Mothers often regard the Matron as a friend and counsellor, much advice is sought and given; follow-up work as necessary is carried out by the Matrons. Parents are encouraged to take an interest in the work of the Nurseries and their children's developmental milestones are reported to them as and when they occur.

The nurseries were well staffed from September to the year-end and this has naturally had its effect by increased admissions. Waiting lists, however, remained constant throughout the year and there are always as many children awaiting vacancies as there are places. On 1st January there were 221 children on the registers and 234 at the year-end. Average attendances have been higher this year than last – 170/200 over 32 weeks of the year as compared to 160/180 over 24 weeks in 1962. The pattern for 1963 was as follows:–

Average Attendances	Reasons given for High or Low Attendances
101 – 140 in 6 weeks	Holiday weeks and one week in severe weather.
141 – 159 in 6 weeks	Colds, measles, holiday weeks, lack of work due to weather.
160 – 169 in 6 weeks	Colds, coughs, mumps, chicken-pox, dysentery, lack of work due to weather.
170 – 200 in 32 weeks	Colds, coughs, mumps, chicken-pox and dysentery recorded.
200 + in in 2 weeks	Xmas Party Week and Mid-July.
52	

Special mention is necessary regarding the severe winter of 1962-63 and its effect on allocation of Day Nursery placings due to inability of mothers to return to or obtain alternative employment due to temporary closing of some firms. By the end of March the position was easier and mothers who so badly needed the means to earn their livelihood were once more in employment.

In total there were 314 admissions and 295 withdrawals, 75% of all new placings were from categories other than financial. We are now able to compare our category of admissions register since its commencement in March, 1962. The admission of acute social problems has shown a steady rise, but not all handicapped children are suitable for Day Nursery care and even when this is offered it is not always accepted.

Category	On Registers at 23/3/62	On Registers at 31/12/62	On Registers at 31/12/63	Admitted in 1963	Discharged in 1963
Illness of parent or confinement	22	17	16	57	50
Acute social problems	25	33	38	49	42
Divorced parents, Unmarried mothers, Separated parents, Widowed parents, Orphaned child	71	74	76	101	95
Mother in essential employment	10	9	11	11	9
Handicapped (parent or child)	9	11	13	14	12
Financial	75	77	80	82	87
TOTALS	212	221	234	* 314	295

* Includes 21 re-admissions, of which 6 were second re-admissions.

Short-stay admissions were as follows :–

Under 2 weeks stay – 39 (mainly at Eccles Old Road and Hayfield Terrace)
2–4 weeks stay – 31 (evenly spread over all five nurseries)
4–8 weeks stay – 37 (mainly Eccles old Road and Bradshaw Street)
Admissions since 1.11.63. – 41 (mainly Eccles Old Road, Hayfield Terrace and Bradshaw Street)

MEDICAL REPORT

During the year each of the five Day Nurseries had four medical inspections and a total of 414 children were examined. Eighty-nine of these children were examined on two occasions and 16 children, who are long-stay cases, were examined three times.

The principal defects found at the medical inspection were :–

"Chesty conditions"	9
Dental caries	18
Enlarged tonsils	12

In the main, the children were found to be healthy and happy.

The following table gives the incidence of illness occurring during the year :–

Nursery	Bronchitis	Chicken-pox	Conjunctivitis	Sonne Dysentery	Non-Specific Dysentery	Diarrhoea	E. Coli	Measles	German Measles	Mumps	Otorrhoea	Tonsillitis	Totals
Hayfield Terrace	–	–	–	3	–	8	1	19	–	8	–	–	39
Bradshaw Street	–	20	–	–	–	–	–	8	1	3	6	2	40
Eccles Old Road	5	8	4	10	–	18	–	2	2	6	–	–	55
Hulme Street	–	4	–	–	–	–	1	–	1	5	–	–	11
Howard Street	6	26	–	–	–	–	–	4	–	6	–	6	48
TOTALS	11	58	4	13	–	26	2	33	4	28	6	8	193
1962 TOTALS	1	52	–	50	14	–	–	92	12	3	–	–	224

Illness has not been so prevalent this year though the early months of the year saw an increase in the incidence of bronchitis, tonsillitis and otorrhoea, due to the severity of the winter. During the summer months there was an outbreak of sonne dysentery at Eccles Old Road Day Nursery, but happily only 10 children were affected. Eighteen children suffering from diarrhoea were excluded from the Nursery, but all specimens referred for examination to the laboratory proved negative.

The value of Day Nursery care for children whose mothers are, of necessity, forced to work to maintain their families must not be underestimated. In many cases the alternative to the Day Nursery is being taken into the care of the Children Department with the resultant break-up of the family, to the detriment of every single member of the family. It is essential for the Health Department to maintain an adequate number of Day Nursery places for such cases and we are always happy to co-operate with the Children Department in preventing family break-up.

Another group of children who need Day Nursery care are those who because of mental or physical handicap have not been able to mix normally with children of their own age. In order to increase the number of children in this category one would like to admit them to the Day Nurseries on a half-time basis.

STAFF, REFRESHER COURSES AND STUDENTS

There were two staff vacancies (one Deputy Matron and one Nursery Nurse) at the beginning of the year and during the year four Nursery Nurses and three Nursery Assistant vacancies occurred; 123 staff working weeks were lost due to inability to fill these places. It was extremely difficult to replace the Deputy Matron and we were unable to replace the four Nursery Nurse vacancies – which occurred from March onwards – until new students qualified in the late summer; the three Nursery Assistant vacancies were more easily filled as these staff are untrained and learn their duties after appointment. At the year end there were no vacancies.

Staff sickness days totalled 586 over the year.

Five refresher courses or conferences were attended by staff as follows:–

January 14th – February 1st, C.C.R. Course, Manchester – 2 Nursery Assistants attended.

Late March, Matrons' Week-end Conference, Bournemouth – 1 Matron attended.

May 15th – 24th, Deputy Matrons' Refresher Course, Manchester – 2 Deputy Matrons attended.

September 30th – October 18th, C.C.R. Course, Manchester – 2 Nursery Assistants attended.

November 13th – 19th, Wardens' Refresher Course, Manchester – 2 Wardens attended.

At the midsummer examination of the Nursery Nurses Examination Board, four students employed during the second year of their training by the Health Committee were successful and gained their diplomas. One of the students has now become a member of the staff of the Day Nurseries, one girl has become a student nurse at Salford Royal Hospital, one girl has become a nanny in a private household, and the fourth girl now works for the Education Committee as a Nursery Assistant. Five new students were appointed to the course in September, 1963.

New regulations for the training of Nursery Nurses were formulated during 1963 and will become operative commencing September, 1964.

NURSERIES AND CHILD MINDERS REGULATION ACT, 1948

There are no private nurseries nor child minders registered with the local health authority under the provisions of this Act.

FAMILY GUIDANCE CLINICS

These sessions have continued throughout the year weekly on Monday evening from 6.30 to 9.00 and Friday afternoon from 2.00 to 4.30, though flexibility of these times is maintained to facilitate working parents as much as possible. The number of persons sent for varies from two to six, depending on whether it is a first or follow-up visit and the nature of the problem. The total number of families on the register was 62 and the number of individuals seen was 94.

The primary presenting factors of disturbance leading to their referral can be divided into three major groups :–

A. Marital Disharmony – 26 familes – 41.05%

B. Behaviour Problem – Child – 24 families – 38.07%

C. Mental Illness – 10 families – 8.06%

The remaining two problems – self-referred – were due to ignorance of sexual matters where factual instruction was all that was needed.

Group A. The Problems of Marital Disharmony

These fall into the following categories :–

1. Immaturity of one or both partners – often forced marriage because of pre-marital pregnancy. Here the difficulties appear to involve every aspect of the marriage – mutual adjustment, psychologically, sexually and financially, being absent. These young couples need great support and education, which one regrets was so lacking in adolescent years.

2. Mental Illness in the other partner. The weight of day to day responsibility is a very heavy one needing much intensive support – for the rest of the family. The situation is often complicated by the fact that the mentally sick spouse often includes the other in his delusions, viz. jealousy quite commonly, and will refuse to go anywhere for treatment, making the fit partner the constant target for punishment when no one else is present, in the privacy of the home.

3. Temperamental Incompatibility – ill-matched couples, e.g. one partner 'extrovert' type – liking to go out most evenings – needing the stimuli of interests and friendships outside the home – the other more introvert and self-sufficient, resenting this. Another cause can be the considerably higher intelligence of the one partner and particularly when this is the wife great problems of adjustment ensue. It is interesting to note here that there were two instances of the husband not being able to read, which caused considerable humiliation in the marriage relationship as well as the difficulty of getting better employment and income. Within this framework we see differences ranging from petty bickering to excessive mutual criticism which provokes jealousy, infidelity, drinking, financial difficulties, wrong parental attitudes.

4. Sexual problems of adjustment, e.g. frigidity due to (a) psychological causes which follow on from above and (b) physical difficulties. There is still a great deal of ignorance and reticence on these matters even today. There is a wide range of normal sexual desire and behaviour, and a frequent difficulty arises when one partner has much stronger sexual desires than the other.

5. Separation from the other partner. Every attempt is made to re-unite the couple and frequent supportive visits encouraged afterwards to keep the marriage on a more stable basis. If the separation is final and complete – the willing partner can be supported and helped in this situation by coming to the clinic to talk about it and so relieve all the pent-up frustration and tension so incurred.

Group B. Behaviour Problems in Child

The causes for this group can be examined under the following main headings :–

1. Poor family life and/or wrong parental attitudes – the one tends to accompany the other – particularly in the former situation. These include sub-normal parents, feckless parents, rigid parental discipline, marital disharmony, mental illness in a parent.

2. Desertion or death of a parent.

3. Physical defect, e.g. speech disorder, obesity and one child previously thought to be enuretic for phychological reasons subsequenlty proved to have a third kidney and her disorder being entirely due to organic causes !

Reasons for referral were boadly :–

1. Conduct disorders – lying, stealing, frequent absences from school, including truanting, aggressiveness.

2. Tension disorders – enuresis, encopresis, temper tantrums, sleep-disturbances, the solitary, withdrawn child unhappy and depressed.

All these had close follow-up in school and the home situation discussed in each case with the appropriate personnel.

Group C. Mental Illness

These were diagnosed as follows :–

Depression – endogenous	– 3 cases	
– reactive	– 3 cases	
– Puerperal	– 1 case	
Schizophrenia	– 1 case	
Manic depressive	– 1 case	} Married to one another with two childre
Low subnormal and delusion	– 1 case	

The depressive conditions responded extremely well to regular supportiv

therapy with the minimum of drugs and with two of the patients with endogenous depression almost certain suicide attempts were averted.

General Assessment

Out of the total number – 25 families – 40.9% made a better adjustment, both to each other and their environment, and no longer attend the clinic. The remainder continue to need supportive therapy apart from five – 8% – who were failures chiefly through lack of co-operation.

Two features stand out:–

1. In spite of great efforts to persuade people who come for advice at a time of crisis, that when this has passed, more intensive work is required to help them understand their own personalities better with a view to improving family attitudes – some fail to see the importance of follow-up and expect to contribute no personal effort at all in the solution of their problems. This leaves many children still at risk and emotionally vulnerable to parental disharmony and wrongful attitudes. Such families can only be helped within the home by the closest case-work.

2. The most constructive and successful work is done where there is a presenting behaviour problem in the child that is not too advanced because if the parents care enough each will make that individual effort first to understand the children's emotional needs and from this – the needs of each other and the rest of the family. Such children are frequently referred by the head-teacher or are discovered at routine school medical examinations.

Close liaison continues to be made between all branches of the service – particularly my thanks are due to health visitors, mental health officers, probation officers and head-teachers for their interest and co-operation at all times.

CONVALESCENCE

Twenty-five families involving 27 adults and six children requested convalescence this year.

The need for accommodation for the mother with one or more young children is still apparent. Every other age group is catered for and considered by charitable organisations – who have done much in this field – but unless an over-tired and over-worked mother is able (or willing) to let her small children be cared for by others there is no provision in the North-West to give her a much-needed respite from her onerous duties.

One has seen, with approval, the rise in holiday homes for the "Aged" since 1948 and wonders whether the "Mother and Young Child" have not been overlooked. Prior to 1948 both these age groups were badly served and it would appear that even one home in the North-West, perhaps used by other branches of the local authority health service or by a group of local authorities specifically for this particular group, could be of valuable assistance to the "Mother and Young Child."

During the year only one mother and child were accommodated together, the child was five years of age and could not therefore be regarded as being in the "young children" group.

Six children, from four different families, were sent to Bryn Aber or Abergele for periods ranging from four to six weeks. The convalescent home officials requested additional stay in three cases due to the poor condition of the children referred, and approval was given in each case.

Nineteen adults were interviewed in connection with convalescence and of these nine were referred to the Civic Welfare Department – three on age grounds and six because bronchitis was the reason for referral. The remaining 10 cases (one man and nine women) were considered for places at St. Annes on Sea, two were entitled to Hospital Saturday Fund benefits and one to the Railway Workers Benevolent Scheme and were therefore referred accordingly. A fourth case was not considered suitable because of the nature of the illness. Five were referred for a two weeks stay at St. Annes on Sea – three of them received assistance from the local authority and a fourth from other sources; the final case was very difficult and very vague regarding income and therefore progress could not be made with the placing, finally the applicant reported that she was removing from Salford.

This year has seen an increase in the number of problem family referrals. They have proved to be very erratic; only one of the four adults dealt with kept to the original arrangements and was co-operative; one deferred her stay at one day's notice, so leaving an untaken bed at the home, a further one defaulted at a day's notice incurring expenditure by the Corporation for the loss of place and the fourth was unhelpful to herself and the Department. In every case the reason for default appeared to be financial although in all cases a very low charge was requested.

INCIDENCE OF BLINDNESS

A1. Registered Blind Persons.

A2. Registered Partially Sighted Persons.

B. Opthalmia Neonatorum.

Blind Person

A1. FOLLOW-UP OF REGISTERED BLIND PERSONS

Total number of cases registered during 1963 – 34

(i) Number of cases registered during the year in respect of which Section F (1) of Forms B.D. 8 recommends :–	Cause of Disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Others
(a) No treatment	3	1	–	13
(b) Treatment :–				
Medical	3	2	–	7
Surgical	3	–	–	–
Optical	–	–	–	2
(ii) Number of cases at (i) (b) above which, on follow-up action, have received treatment	2	2	–	8

A2. FOLLOW-UP OF REGISTERED PARTIALLY SIGHTED PERSONS

Total number of cases registered during 1963 – 22

(i) Number of cases registered during the year in respect of which Section F(1) of Forms B.D. 8 recommends :–	Cause of Disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Others
(a) No treatment	–	–	–	1
(b) Treatment :–				
Medical	4	2	–	9
Surgical	3	–	–	–
Optical	–	–	–	3
(ii) Number of cases at (i) (b) above which, on follow-up action, have received treatment	4	2	–	12

B. OPTHALMIA NEONATORUM

(i) Total number of cases notified during the year — Nil

(ii) Number of cases in which :–

(a) Vision lost — Nil
(b) Vision impaired — Nil
(c) Treatment continuing at end of year — Nil

HEALTH VISITING SERVICE

The Health Visiting Service covers general health visiting, including care of expectant and nursing mothers and children under five years, health education and social advice for all age groups, special services for vulnerable groups within the community, e.g. elderly persons, unmarried mothers and their children, socially handicapped families and tuberculous persons. The section also undertakes a full school health visiting service; liaison with hospitals including special work for diabetics; provides practical training for student health visitors and assists with the training of student nurses in social aspects of health and disease. Special auxiliary services include a central syringe service, and domiciliary bathing and foot hygiene services for aged, infirm persons. Administrative work for the Chiropody Service is also carried out.

Needs of vulnerable groups make progressively greater demands on the service, and many additional duties in the preventive and supportive fields have devolved on staff of the section over recent years. More attention, for example, is paid to preventing the development of maladjustment, child neglect, and the break-up of families, which involves greater attention to budgeting and debts and more supportive care. The section's considerable contribution to the reduction in incidence of infectious diseases by vaccination and immunisation has been achieved only by unremitting care and team-work. Assessment of priorities is one of the difficulties arising from these developments.

The traditional role of the health visitor in the field of maternity and child welfare, for example, has tended to become obscured and the needs of mother and child submerged by the more pressing requirements of other groups. It is not easy for the health visitor to decide whether, e.g. health of the baby should take precedence over well-being of the toddler or care of an emotionally disturbed adolescent, the family doctor's patient, a disturbed school child, or a family where there is physical or social handicap.

Added to the increased scope and volume of work has been the problem of reduction in working time resulting from the national decision last year to increase annual leave – which reduced the working time of staff by some 2%.

At the end of the year the total staff numbered 63, of whom 49 were professionally qualified workers and 14 nursing auxiliaries.

Retirement

Miss A. Hardwick, Deputy Superintendent Health Visitor, retired on superannuation in October after 31 years service. Miss Hardwick had worked in the City as Health Visitor and as Centre Superintendent before her appointment as Deputy Superintendent in 1953. She played no small part in the development of health visiting in Salford, from a small section dealing only with maternity and child welfare to a comprehensive service covering all the fields previously mentioned in this report. That her work was appreciated nationally was evidenced by the award to her of the Coronation Medal, but only the department can know of the real contribution she made to the well-being of families in Salford. We would like to place on record our thanks for and appreciation of her work.

SPECIALIST SERVICES

(a) AGED AND INFIRM

The number of persons referred to the section during the year was 1,201. The highest number came from Regent Ward. The age-group from which most cases were referred was 70 to 74 years.

In all 5,025 cases were dealt with during the year, women predominating as in former years.

State of Activity (new cases)

Bed-ridden	107
Home-bound	171
Semi-ambulant	261
Ambulant	662
	1,201

Cases were referred by :–

Civic Welfare Department	170
Found by Health Visitor during other visits	150
Area Health Visitors	44
General Practitioners	71
Home Help Service	26
Hospitals	143
Mental Health Service	13
Relatives, friends and personal applications	412
Public Health Inspectors	9
Housing Department	73
Voluntary Organisation	7
District Nursing and other Statutory Organisations	83
	1,201

Health Reasons associated with Referrals :–

Alone and neglected	4
Cancer	37
Chest	118
Diabetic	49
Incontinence	30
Kidney	1
Rheumatic Conditions	97
Senile Mental	27
Vascular	76
Cardiac	52
Nervous diseases	16
Blind	16
Deaf	28
Chiropody	312
Other Conditions	338
	1,201

It may be of interest to note the number of persons on the 1963 Register in relation to the year they were referred. Particulars are given below:—

Year Referred	Male Remaining on Register	Female Remaining on Register	Total still on Register
1950	2	51	53
1951	5	24	29
1952	6	26	32
1953	33	108	141
1954	47	134	181
1955	36	172	208
1956	57	173	230
1957	56	180	236
1958	48	163	211
1959	68	289	357
1960	126	560	686
1961	104	453	557
1962	185	718	903
1963	314	887	1,201
Total	1,087	Total 3,938	Grand Total 5,025

Home Visiting

A health visitor pays the initial visit to assess the need and decide how best the elderly person may be helped. If appropriate, subsequent visits may be paid by a clinic nurse. At every first visit an addressed correspondence card is given with instructions as to how the department may be contacted between visits should the need arise. Persons living alone are given primary consideration and when problems arise visits are in all cases paid frequently in order to help over the difficult period. Referrals are made, where appropriate, to the various statutory and voluntary agencies dealing with old people, many of whose workers are known personally to the health visitor.

Auxiliary Services for the Elderly

The section arranges for home bathing of elderly (not sick) persons who by reason of frailty or infirmity are unable to perform this service for themselves. For those able to bath themselves but unable to carry out the physical manipulation necessary for, or owing to defective vision are unable to give proper care to, the feet, a home-hygiene service is provided. In both instances nursing auxiliaries attached to the section carry out these services in the home at regular intervals. For those needing the more skilled attention of a chiropodist both clinic and domiciliary chiropody services are provided. The health visitor visits all persons referred by any agency for chiropody so that all cases for treatment are channelled through the section. They are assessed according to need for domiciliary treatment, or clinic attendance by sitting-car or by public transport. Arrangements for transportation by sitting car are made by the section and all statistical and administrative work in relation to the chiropody service is also undertaken. Foot hygiene services by nursing auxiliaries may be carried out between chiropody appointments in appropriate cases or when on the waiting list for treatment (provided the patient is not suffering from diabetes or from circulatory trouble).

Clinics for the Elderly

Weekly medical examination sessions are held alternatively for men and women at Langworthy Centre, when a physical examination is made by a doctor and opportunity to discuss any personal problem with the health visitor is given. If physiotherapy is prescribed treatment may be carried out at the same centre.

Liaison with Other Services

Hospitals

There is seldom a waiting period of more than a week except during the bad winter months of January and February, when there is usually an increase in requests for admission. The Day Hospital at Ladywell has been of great value. Some of the patients discharged from the wards may attend several times a week – they are transported by ambulance in the morning and returned home late afternoon. Treatment is mainly of a rehabilitative nature, which helps the patients to re-adjust themselves to living at home. Meals and baths are provided.

District Nursing

A good friendly relationship exists between workers of both services and an exchange of social and nursing problems freely made. Nursing equipment is loaned through the District Nursing Service, which also arranges the Laundry Service for incontinent persons.

Home Helps

Home helps are provided for many elderly persons. A Night Sitting Service, when needed, may also be arranged through this service. Home helps keep the section well informed of any change in the physical or home conditions of those they are attending. This is followed up immediately by a visit from the health visitor.

General Practitioners

Direct and increasing contact with the Elderly Section is made by many doctors, either by telephone or correspondence card, others refer cases through the health visitor responsible for liaison between a given general practitioner and other health visitors.

Mental Health Service

The present trend towards referring 'early' cases to the Mental Health Department needs to be followed with caution when dealing with old people. Forgetfulness or behaviour which does not conform to usual day-to-day standards is often put down to mental disease and referred accordingly. Experience however shows that many of these people are suffering from undernourishment, anaemia, circulatory or other physical conditions or there may be predisposing causes such as loneliness. Attention to physical health often works wonders in restoring normal behaviour. Where there has been loss of a partner, even worse than the fear of living alone is the fear of

being obliged to enter a local Authority Home. Community life in a large centre is a change of environment too drastic for many of the old folk to contemplate – the more homely way of life in the smaller Local Authority Homes is much to be preferred should institutional care be necessary. Every effort is made to promote physical and mental well-being and to help these citizens to live happily in their own homes as long as possible.

Civic Welfare

We enjoy very friendly and helpful co-operation with members of the Civic Welfare Department staff. Through this department holidays for the elderly may be arranged at the Kirkdale Holiday Home in Southport, admissions to the "Homestead" for those in need of institutional care, and help in many other ways. For example we were in difficulties with a deaf and dumb elderly couple living in disorder and squalor, and with whom we were unable to communicate. The Welfare Officer for the Deaf was approached and he accompanied the health visitor and a public health inspector to the house and conversed with the couple at length by hand signs, interpreting on behalf of all parties. As a result we were able to arrange for repairs to be carried out and some cleansing to be done, and other help given.

Cripples Aid Society

Staff of this organisation collaborate by visiting selected handicapped persons when requested and arranging loan of wheel chairs, commodes and other aids. They may also arrange for attendance at Outings and Club and providing transport when necessary.

W.V.S.

Meals on Wheels are provided and distributed by this Organisation – a very much appreciated and valuable service for elderly persons. Unfortunately supplies are limited and there is a long waiting list of applicants for meals.

Lack of accommodation resulted in the closing down of the Organisation's Clothing Depot – a greatly missed service.

Booth's Charity

Some 1,200 elderly people in Salford receive 10/- a week from this source. New bed-sitting room flats, easy to run, well-equipped and in pleasant surroundings have been built and let to elderly people by this organisation.

National Assistance Board

Officials co-operate by referring to us elderly persons thought to be in need of our care.

Bring and Buy Sale

Staff of the Section organised the annual Bring and Buy Sale, proceeds of which were divided between the Children's Welfare Fund and the Elderly

Persons' Fund. Grants from this fund were made to elderly persons where statutory and other voluntary organisations could not meet the particular need.

Claremont Open Air School sent Harvest Festival Fruit which was distributed. Names were given on request to several organisations wishing to present gifts or samples, or meals and entertainment at Christmas.

Future Need for the Elderly

Day Centre

A need which we hope to meet in the future is a Day Centre – where elderly people of both sexes could spend the day. This would not only meet the needs of the lonely and depressed and perhaps prevent, or at least delay the onset of a mental breakdown – it would meet the increasing needs of the many elderly people who have been re-housed into flats. Here they are often among strangers and young neighbours who go out to work. The loneliness is sometimes almost unbearable. An example may be given of an old man practically home-bound who was re-housed into an upper storey flat in the Trinity area. He told the health visitor he rarely saw anyone apart from his home help once a week. His window looked out on to the roof of a factory and the only sound he heard was the occasional clang of the lift gate – surely worse than a prison.

At the end of the year :–

	Of new cases referred in 1963	Of those already on Register 1963	Total
Died : Male	21 } 50	158 } 491	179 } 541
Female	29 }	333 }	362 }
Admitted to Hospital	35	315	340
Admitted to Local Authority Home	12	81	93
Removed from Salford	27	105	132
Referred to Area Health Visitor	6	7	13
Referred to Mental Health Dept.	2	8	10

Remaining on Register 31.12.63 – 3,886 (2,464 of whom lived alone)

(b) HOSPITAL LIAISON

Two special health visitors are employed in this work, one attached to Hope, Ladywell and Salford Royal Hospital, the other mainly concerned with the Chest Clinic.

Hope Hospital

(i) Paediatric Liaison

Work here is mainly concerned in working closely with the Consultant Paediatrician and with the speedy exchange of information between hospital

staffs regarding diagnosis, treatment and behaviour, and area health visitors in relation to home circumstances and after-care. Information must be passed on quickly if it is to be of any value. Hospital staffs mainly concerned include ward sisters and nurses, almoners, medical and certain administrative staffs.

The volume of work involved in dealing with information pertaining to all child admissions became too much for one person to cope with, and a more selective and fruitful method of case finding was instituted, in which ward sisters, nurses, doctors and almoners participated. Between 50 and 60 referrals were made to area health visitors each week. This figure included out-patients attenders as well as in-patients.

(ii) Diabetic Clinic

In May, 1963, health visitor liaison was started in connection with the Diabetic Clinic at the request of the Consultant Physician. All unstable diabetics and those with problems were referred to the health visitor who also collaborated with the almoner dealing specifically with diabetic patients. The health visitor personally carried out all home visits and also contacted general medical practitioners to discuss and adjust the treatment routine.

Since liaison with this clinic was started in May, some 20 patients have been referred, and 65 home visi ts paid.

Salford Royal Hospital

Liaison work here is confined to the Diabetic Clinic and the same type of problems arise with patients attending both hospitals. For example patients have been found to be using the wrong type of syringe and consequently unable to measure the correct amount of insulin. Two patients were having repeated episodes of illness peculiar to untreated diabetics, another patient was very badly controlled because she was not taking the full dose of insulin prescribed. One patient revealed that instead of having two injections of insulin daily she gave herself only one. Following the health visitor's consultation with the physician the patient was subsequently admitted to hospital for stabilisation and was discharged home on a long-acting insulin requiring only one injection a day. A further patient frequently gave herself the wrong dose of insulin – 80 instead of 48 units because she misheard the doctor's instructions and later because she forgot to increase her dosage when requested. The health visitor called on the patient's family doctor to discuss the case, after which the patient was issued with a pre-set syringe which was checked from time to time and found to be a very satisfactory arrangement for this patient.

There is a wide scope for health education in this field of work. Applied individually this helps the patient to appreciate the importance of carrying out medical advice in order to become adjusted and attain a proper physiological balance – and thus become as far as possible independent. More success is achieved by teaching this type of patient in their own home than by any other method. Also important in this field is close collaboration with the chiropody service, as diabetic patients are especially prone to foot damage following unskilled pedicure.

The number of patients referred to the health visitor from this clinic during the year was 60, the number of visits paid 194.

(c) CHEST CLINIC LIAISON

A special health visitor is employed who attends the Chest Clinic and acts as liaison officer between chest physician, patients, and health visitors.

The better understanding and use of her services by the hospital specialist medical service, the general practitioner and the public, which was slow to develop in the earlier years, has markedly improved, and the health visitor is now a well established member of the Chest Clinic team. Her work is concerned with the social and psychological aspects of the patient's illness and problems arising therefrom.

Interviews were conducted as follows :–

All new patients and relatives accompanying the patient,

Patients referred for hospital admission – whatever the reason, e.g. Tuberculosis, Observation, Cancer, Bronchitis,

Patients referred by the Chest Physician,

Patients, relatives or contacts wishing to see her.

The health visitor explains the purpose of hospital treatment, if appropriate, tells the patient what to expect, dispels fears and helps begin formulation at an early stage in both patients and relatives of the right attitude towards the illness and treatment. She gives information regarding social agencies and types of benefit available, and contacts the different statutory and voluntary agencies on behalf of the family where appropriate. The problems arising are very varied and include housing and/or financial difficulties, strained family relationships, psychological upsets, difficulties which may arise in connection with care of children and care of the home. She may also arrange adequate nursing and care of the patients at home – attendance of contacts for examination at the Chest Clinic and for immunity testing and B.C.G. vaccination.

Tuberculosis

There was a slight increase in the number of notifications of this disease (73 compared with 70 last year). Contact examinations appear to be more readily accepted and the demand for B.C.G. maintained.

Number of notifications	73
Mantoux Tests	391
B.C.G.	245
Patients interviews by Health Visitor	250
Almoner interviews by Health Visitor	10
Chest Consultant interviews by Health Visitor	140
General Practitioner interviews by Health Visitor	5

Bronchitis

The greatest number of attenders at the Chest Clinic are sufferers from

bronchitis. In addition to advising socially and otherwise as for tubercular patients the health visitor carries out further health education where appropriate, especially in relation to cigarette smoking, and to the importance of taking advantage of M.M.R. services when available.

Lung Cancer

The number of cases referred to the Consultant Thoracic Surgeon by the Chest Physician has increased. The health visitor may visit such patients in hospital, gives supportive care where necessary and helps towards rehabilitation after operation.

The interchange of information between the Chest Clinic and area health visitors remained an integral feature of the liaison health visitor's work.

(d) THE UNMARRIED MOTHER AND HER CHILD

This work was carried out by a special health visitor until the end of October when she left. There was no response to advertisements for the post which was still vacant at the end of the year.

Altogether 142 cases were dealt with, of which 35 were old cases carried over from 1962, and 107 new cases.

Of the new cases 37 were expectant mothers, 29 of whom were single girls expecting first babies, four expecting second babies and four expecting their third illegitimate child.

New cases were referred from the following sources :–

	As Expectant Mothers	After Confinement	Total
General health visitors	5	26	31
Moral Welfare Agencies	14	4	18
General Practitioners	2	–	2
Midwives	2	1	3
Almoners	1	16	17
N.A.B.	–	1	1
Children Department	1	4	5
Prison Welfare	–	2	2
Adoption Society	–	1	1
Other Local Authorities	2	2	4
Own Family	4	–	4
Own initiative	6	7	13
Found whilst visiting	–	6	6
	37	70	107

Advice was given appropriate to individual needs and included information regarding maternity and other benefits, help with financial problems, accommodation, layette, prams, cots and other material needs; supportive care, in particular where the girl was without friends or relatives; helping to further family and personal adjustment to the situation; advising as to Affiliation Order procedure where sufficient evidence was available, and help with care of the baby later where necessary

In those cases where hostel accommodation was sought as the most appropriate means of meeting the problem, arrangements were made through Moral Welfare Organisations. Applications were also made by Moral Welfare Agencies for financial assistance towards hostel fees on behalf of these and other Salford girls – local authority grants were made in respect of a total of 31 unmarried mothers – all of whom had been resident in the City for over 12 months. Many babies in these cases were later adopted from the hostels.

During the year, of the new cases dealt with to 31st December, 1963:–

	New Cases	Old Cases	Total
Removed from Salford	13	10	23
Married	3	5	8
Babies adopted	8	3	11
Mothers keeping their babies	8	7	15
Living with mother's parents	3	5	8
Cohabiting	16	5	21
With foster-parents	1	–	1
Died	1	–	1
Stillbirths	3	–	3
Found not to be pregnant	1	–	1
Carried over to 1964	50	–	50
	107	35	142

(e) TRAINING OF STUDENTS

A specially appointed health visitor (later re-designated Assistant Superintendent Health Visitor) who acts as tutor in practical work to student health visitors and assists in the training of student nurses in social aspects of health and disease, is in charge of this work. She also deals with the needs of members of outside organisations visiting the section.

Student Health Visitors

The full practical training of student health visitors is given to Salford sponsored students taking the Manchester and Bolton training courses. All work is arranged by the Assistant Superintendent Health Visitor in collaboration with area health visitors and other members of the Health Visiting Section staff. Two students finished the course, and both passed the examination. Five students started the new course in September, 1963.

Student Nurses

Assistance in teaching student nurses the social aspects of health and disease was continued, the time spent by individual students varying from one to three days, according to the needs of the hospital and stage in training of the student.

Students are taught the need for full co-operation between hospital, family doctor and local authority services in order that the patient may derive maximum benefit from his stay in hospital. They learn something of the preventive health services and are helped to see the tripartite nature of the

National Health Service in proper perspective; they are made aware of the effect which living, working and social conditions may have upon health and welfare and of the services which exist to help those in need. In learning of the difficulties and problems which may lead to a breakdown in physical and mental health the students become more readily aware of possible difficulties which may arise as a result of hospitalisation, and are able to treat the patient accordingly.

Group meetings were held at which obscure points were clarified and ways and means of applying the principles learned in the department were discussed.

The following groups of student nurses visited the department as follows:–

Hope Hospital
48 junior students in 4 groups – 1day each
81 senior students in 5 groups – 2 days each

Salford Royal Hospital
42 junior students in 6 groups – 3 days each
9 senior students in 2 groups – 3 days each

Royal Manchester Children's Hospital
40 students in 3 groups – 3 days each

Crumpsall Hospital
19 students in 2 groups – 1 day each

Jewish Hospital
19 students in 2 groups – 1½ days each

Nursery Nurses
31 students in 5 groups – ½ day each

Community Nursing Students
11 students in 6 groups – ½ day each

Bolton Student Health Visitor
1 student for 4 days special experience.

Other Visitors to the Section

Other students and visitors dealt with in the department included a hospital administrative student from the Royal College of Nursing; a group of student teachers from Sedgley Park Training College; and a house officer from Hope Hospital taking the Diploma in Child Health.

Talks to outside groups were again arranged, e.g. to Mothers' Clubs, Mothers Unions, Darby and Joan Clubs.

A talk was given to members of the staff of the Children Officer and another to School Welfare Officers.

At a symposium arranged by the Chest and Heart Association in Salford

during the year a short paper was read on the role of the health visitor in relation to chronic bronchitis in children and adults.

In-Service Training

Newly-appointed clinic nurses were given in-service training by the tutor. They were taught for example, the practical aspects of their own particular work and the approach to families in their own homes. They were also given some insight into the work and aims of the public health department personnel. Newly-qualified health visitors were also helped and guided as required.

The series of discussion groups of six to eight health visitors with the Child Psychiatrist as Group Leader, which was started over eight years ago, continued to function until July, when the Psychiatrist left the service.

(f) PREVENTION OF FAMILY BREAK-UP – CHILDREN NEGLECTED IN THEIR OWN HOMES

Aims of this service are – as its title implies – to prevent the unnecessary break-up of family life; to prevent where possible the neglect of children in their own homes; to seek to alleviate the suffering of children where neglect already exists and to promote health in all its aspects wherever possible.

The special health visitor who has worked in this sub-section of the service since 1959 continued the seemingly endless stream of work in this field. The pressures and needs which led to the appointment in 1962 of a second health visitor to assist, still remained, but when the latter left the service in April, 1963, it was impossible to replace her and this post was still vacant at the end of the year.

Problem Family Register

To the 234 families on the register which were carried over from 1962, a further 21 new cases were added. These figures relate only to established problem families and do not include potential problem families or families at risk.

Although the new cases were greater in number than those of last year (21 against 15), the total number needing the service was slightly fewer (255 against 261).

This rise in the number of new cases is disquieting but does not necessarily mean that family standards are falling in Salford. For example, of the 21 new cases 4 were nomadic types of family from another area moving from one sub-let house to another, 3 were families moving in from County Part III Accommodation to Salford multi-occupation houses (and at least one of whom because of the Regulations applying to these houses was subsequently evicted to Salford Part III Accommodation), 3 were tinker families from Scotland, and 1 from Wales. There were in addition three families on the register where in each instance two mentally subnormal people had married, produced children, and become problem families. Developments in relation to problem families which may arise in the future as a result of implementation

of the Mental Health Act could result in no small increase in the incidence of and work for families coming into this category.

The special health visitor continued to act in a consultant capacity to her colleagues and to undertake some intensive casework with a limited number of "hard-core" problem families. She was also concerned with organisation of the Case Conference, liaison with H.M. Prison, Strangeways, consultant duties at the Day Training Centre for socially handicapped mothers, and with an advice service to members of the general public who may call at or are referred from various sources to the Health Department.

Problem Families

Problems relating to these families do not vary a great deal and may be associated with physical and mental illness or defect, poor housing, overcrowding, dirt, disorder and squalor; debts, the cutting off of essential gas and electricity supplies, threats of eviction, poor school attendance, truancy, recurrent illnesses of family members, with mothers in constant state of sub-normal health; desertion by either parent, delinquent or criminal tendencies, drunkenness, imprisonment, ignorance and poor parentcraft, poor personal relationships and so-on.

These signs and symptoms are often found in some form of combination in hard-core problem families. Many such families have a multiplicity of chronic interlocking problems. The breakdown of family relationships which so often is the centre of problem family troubles may sometimes be traced to personality defects or mental subnormality of the parents.

Although not all problem families present difficulties to the same degree they all suffer from social defectiveness to the extent that they require care, supervision and control for their own well-being and the well-being of others in the community.

Such families rarely consider themselves to be problematic in any way. Sometimes the children are potentially better material than their parents and often a strong partner or one stable person in the family makes a great deal of difference to the worker attempting casework. Not all families require casework in depth, but those who do may be referred to social casework agencies such as the Family Service Unit – who dealt with 22 families during the year – the Family Welfare Association, and the women's worker for the N.S.P.C.C. The health visitor also works with and through other agencies such as the Family Doctor, Probation Officer, School Welfare Officer, Children Officer, and various voluntary agencies and religious bodies. The special health visitor undertook casework with 8 "hard-core" problem families.

In seeking to rehabilitate these families full use is made also of other health department services, e.g. Day Nursery, Home Help Service, Family Guidance Clinic and the Day Training Centre.

Day Training Centre

This Centre at Acton Square continued to provide for a limited number of mothers with special problems. Here the tired, friendless and apathetic mother is helped by group therapy to become more sociable and more able

to perform her household tasks. She is taught individually and informally simple cookery and sewing and care of her home and children. The sense of belonging and the group feeling are all-important to these socially isolated mothers and the improvement in their physical and emotional health clearly shows the benefit of this service. It is valuable, too, in that it fulfils the role of a "Brentwood" without the disadvantage of family disruption and high cost.

An average of 9 mothers and 15 children attended each week.

In order to co-ordinate the various activities of workers in these fields regular Case Conferences were held during the year.

Case Conference

Conferences were held fortnightly under the Chairmanship of the Deputy Medical Officer of Health, and latterly by the Child Health Officer. An average of 8 problem families per meeting was discussed.

Achieving effective co-ordination is no easy task, and is dependent to a large extent on the degree of co-operation extended by the organisations involved. Failure of local authority departments to channel information to the Co-ordinating Officer, or secrecy about their activities in relation to the families concerned causes confusion and overlapping of services, the very conditions which the Case Conference seeks to prevent.

During the year:—

Number of conferences held		20
Organisations and Departments represented		19
Number of representatives attending		110
Average attendance per session		16
Number of discussions held		154
Number of families discussed		104
Number of families discussed once	70	
Number of families discussed twice	23	
Number of families discussed three times	7	
Number of families discussed four times	4	

Potential Problem Families

Potential problem families are those living under circumstances and conditions which could degenerate into the true problem family situation. They are however usually amenable to advice and with support may be kept above this level—here lies the great field for preventive work. The area health visitor is in the front line of defence in these cases. With these, as with established problem families, she does not work in isolation but works with and through other agencies where appropriate.

Family Advisory Service

Any member of the Salford public may seek advice from the Health Visiting Service on a health, family, social or personal problem. The special health visitor concerned with problem families sees all cases in the first instance.

During the year 281 families were dealt with (238 in 1962). The problems involved were concerned with the following:–

Expected confinement	13
Mental illness of parent	28
Bereaved husband or wife	8
Desertion by either partner	37
Illegitimate pregnancies	3
Physical illness of parent	47
Mentally subnormal parent	8
Marital disharmony	18
Threatened eviction	58
Miscellaneous problems relating, e.g. to debts, material needs, handicapped children, prisoners' wives, and other medico-social problems	61
	281

Prevention of Family Break-up

The work undertaken by the Advisory Service helps in no small measure to prevent the break-up of families. Probably the most direct serious threat to the stability of family life is the possibility of eviction, with a consequent temporary break-up and occasionally permanent break-up of the family. Of the 58 families who sought the help of the special health visitor in the prevention of eviction – 51 evictions were prevented and only 7 actually took place.

Marital Disharmony

18 cases of marital disharmony involving 54 children were dealt with. With the help of the Family Guidance Clinic, Probation Service, Marriage Guidance Clinic, Catholic Marriage Advisory Council and casework by the health visitor a breakdown was prevented in every case.

Desertion

37 people sought assistance following desertion by a partner. In some instances the offer of Day Nursery placement and the services of a Home Help enabled the remaining family to cope. In other cases wives had to be directed to the N.A.B. and advice given regarding legal separation. The services of the N.S.P.C.C. proved most useful in tracing the absconding partner, and in 5 cases reconciliation was effected.

Death of One or Other Parent

This is a much more complex problem, where apart from the physical loss and subsequent material loss to the family the emotional element may be the most difficult factor to overcome. This concerns not only the remaining partner but is manifest in the children also, and may give rise to serious behaviour problems later. As with other cases supportive care was given and the help of other agencies called upon as appropriate.

Prisoners' Families

Again another cause of temporary family break-up. 59 prisoners' families

were referred to this department. These families form a section of the community needing all the statutory and voluntary services available, as the wives and children appear to suffer more than the prisoner. He is deprived of his freedom but at least is afforded some sense of "security" which his family lacks. In December 45 of the 59 prisoners had completed their sentences and were discharged.

Homeless Families

In 1963, the total number of families requiring Part III Accommodation rose steeply to 30, only seven of which were known to the health visitor prior to eviction.

Reasons for eviction were as follows :–

Rent arrears or non-payment of mortgage		11
Domestic disharmony		12
Miscellaneous		
(a)	Sub-tenant of an evictee	7
(b)	Business failure – family could no longer be accommodated by relatives who took them in after the failure	
(c)	Unmarried mother of no settled abode	
(d)	Desertion by mother, and landlord would not tolerate father and children	
(e)	Family from Lancashire County Part III Accommodation transported to rooms let in multiple occupation causing overcrowding and an offence against the Housing Act, 1961 and Regulations	
		30

15 of the 30 families were provided with sub-standard houses by the Housing Department. The excellent collaboration of the Housing Department has helped very considerably to prevent evictions as well as to deal with homelessness.

The 30 families concerned had a total of 83 children between them, 49 of whom went into care for an average of 8.3 days

Rehabilitation

The health visitor is advantageously situated because she has easy access to all homes where there are young children, and can not only detect early signs of deterioration, but is also able to assist with rehabilitation. Her services are usually well received and she can refer the family at an early stage, if appropriate to other statutory and voluntary bodies. The Salford Children's Welfare Fund has been used as formerly in making provision for families where statutory agencies were unable to meet the need. There are provisions in the Children and Young Persons Act 1963 which will in the future fulfil some of these needs.

The Future

Changes are in the air which will be realised when the Children and Young Persons Act 1963 is fully implemented. But the aims will remain the same – to assist people, normally those who have failed in some way and require help. The changes which may take place in administration have not yet been decided. Perhaps what is needed is a therapeutic team, members of which may include the general practitioner, the Medical Officer of Health and health visitor, probation officer, N.S.P.C.C., school welfare officer, child care officer, F.S.U., teachers, and special caseworkers such as psychiatric social workers. In any eventuality –

(a) It is of primary importance that work shall be done for and with the family unit in its own environment,

(b) We should be prepared to give varying kinds of help particularly in relation to crises,

(c) Agencies must communicate with one another and act as a team.

Are Problem Families Worth the Time and Effort?

For the social worker who is really interested in people, no field could be more worthwhile than this. These clients challenge everything one believes in and does. If we are to prevent the same number or a possible increase in numbers of problem families in the next generation then positive action is indicated now – perhaps a Community Care Service offering care and prevention.

Prevention – to be effective – must be based on :–

(a) Improved family care and enlightened handling of deprived children,

(b) Better training and education for family life and good citizenship while at school and afterwards,

(c) Improved physical and environmental conditions.

Our efforts should continue to be directed towards keeping the family together – in happiness – in their own homes. Altogether a long, slow process – but the goal very worthwhile.

IMMUNISATION

Immunisation and vaccination were offered – as formerly – at all child welfare sessions in all clinics throughout the city.

The domiciliary immunisation scheme was modified to enable earlier protection to be given to young babies. At her first visit after birth, the health visitor discusses immunisation with the mother and obtains where possible her written consent to this protection for her child. When the baby is 6 to 8 weeks old the health visitor re-visits in the ordinary way and at the same time gives the first injection of triple antigen and the first oral dose of polio vaccine (and at this visit she also undertakes the Phenylke-

tonuria test). The mother is invited to bring the child to a clinic for subsequent injections. If she fails to attend the health visitor may herself complete the immunisation in the home, or, at her discretion, may arrange for a clinic nurse (State Registered Nurse) to perform this service.

HEALTH VISITORS AND FAMILY DOCTORS

Close collaboration between the health visitor and family doctor, observed to some extent for many years, was extended by the allocation of more liaison health visitors to certain doctors. The health visitors involved visit the surgeries at regular weekly intervals in order to discuss patients living on their areas, and to transmit requests and information from the doctors concerned to health visitors responsible for home visiting in other areas. The "outside" health visitors contact the doctors by telephone at a pre-arranged convenient time to report on cases referred to them in this way.

In some local authority areas it has been possible to allocate health visitors to cover entirely the whole of a doctor's practice, and requests have been made by some general practitioners for similar arrangements to be made in Salford. Administratively this would be very difficult as a doctor's practice covers a much wider area than that of the average health visitor. A spot check relating to a group of three doctors making such request revealed that their practice extended over the areas of no fewer than 16 health visitors and almost half the geographical area of the city. There were, of course, other doctors covering these areas also. A further check relating to one part-time health visitor with a case load of approximately 275 families revealed that no fewer than 51 family doctors including two doctors from Lancashire County were responsible for the medical care of persons making up this case-load in an area covering little more than ½ to ¾ of a square mile. Little imagination is needed to visualise the wasteful overlapping of visits and administrative chaos which the allocation of individual health visitors to each group of doctors covering this area would mean.

There is however no doubt about the value of health visitor/general practitioner collaboration, but short of both workers being made solely and jointly responsible for services in one given area it is unlikely that the allocation of health visitors entirely to cover doctors' practices can ever become a practical possibility in a city of this kind.

Much good work has none-the-less been done during the year. Health visitors not only pay home visits following request by the family doctors – some attend well-baby clinics held by the general practitioner, others attend special surgery sessions to which the doctor has invited patients with special problems; others again attend the surgery to hold a special health visitor advisory session in the absence of the doctor—mainly for patients with young children. We would like to place on record our appreciation of the co-operation of the general practitioners concerned in all aspects of this co-ordination of effort.ffort.

STATISTICS

A statistical summary of visits paid and clinics attended by all members of the Health Visiting Section, viz., health visitors, clinic nurses and nursing auxiliaries, is given as follows :–

Health Visitors and Clinic Nurses

Type of Visit	Access	No Access
Total visits to children 0 – 5	30,245	
Ante-natal visits	511	
Visits to tuberculous persons	1,001	
Visits to aged persons	6,691	
Special hospital discharge visits	147	
Mental Health visits	450	
Immunisation visits	4,632	
Miscellaneous	4,590	
No access visits		8,350
Total	48,267	8,350
Grand Total	56,617	

Clinic sessions	Health Visitor	Clinic Nurse
Full session	1,995	487
Part session	37	3
Total	2,032	490

Nursing Auxiliaries

Type of Visit	
Bathing – babies	15
Bathing – Aged infirm	1,765
Scabies	10
Foot hygiene – Aged infirm	3,085
Miscellaneous – Aged infirm	1,098
Miscellaneous – general	92
No access	808
Total	6,873

Nursing Auxiliaries – Clinic Sessions

Type of Clinic	
Ante-natal	8
Infant Welfare	390
Day Training Centres	736
School Minor Ailments	802
School Chiropody	322
Scabies sessions	8
Eye Clinic	516
School medical examination clinic	24
Bathing and cleansing session (includes head cleansing and weekly bathing of motherless children – 435 baths)	50
Camp and Miscellaneous (including M.M.R. Survey)	260
Cleansing (including re-inspections)	26
Total	3,142

School Sessions (in collaboration with health visitors)

Type of Work	
Health Survey	238
Vision Testing	115
Hygiene Inspection	245
Hygiene Re-inspections	77
School medical inspections	33
Short visits to schools	40
Immunisation in schools	58
Total	806

Syringe Service

Sessions spent	736

HOME NURSING SERVICE

The District Nursing Service has fulfilled a year of valuable and professional service to the community, bringing skilled nursing care and comfort to people of all ages in their own homes.

EXPANSION OF WORK

Once again there has been an increase, both in the number of patients and visits, this is clearly indicated by the following comparisons over two years:–

Number of patients carried over – January 1962	
From previous year	466
New patients	1,810
Total number of patients nursed	2,276
Cases closed	1,729
Patients carried forward	547
Number of patients carried over – January 1963	
From previous year	547
New patients	1,907
Total number of patients nursed	2,454
Cases closed	1,892
Patients carried forward	562

Comparison of total visits – 1963 – 62,111
1962 – 55,660

STATISTICS

Number of patients on the books January 1st 1963		547
Number of new patients during the year		1,907
	Total	2,454
Number of patients removed from the books during the year		1,892
Recovered		886
Removed to hospital		353
Died		247
Removed from area		30
Removed for other reasons		376
Number of patients remaining on books at the end of the year		562
	Total	2,454
Number of visits made during the year	Total	62,111

BY WHOM PATIENTS WERE REFERRED

Family doctors	1,400
Hospitals	383
Health Visitors	56
Midwives	10
Personal applications	41
Others	17

SOURCES OF REFERRALS

Family doctors	1963	1,400
	1962	1,349 (an increase of 51)

We are pleased that the family doctors have continued to make use of the Home Nursing Service, and we hope the increase of referrals will continue.

HOSPITAL REFERRALS

1963	383
1962	329 (an increase of 54)

Of these cases 146 were post-operative, requiring surgical dressings; 201 were for treatment prior to x-ray investigation; the remaining number required injection therapy, general nursing care and rehabilitation.

HEALTH VISITORS

56 cases were referred from the Specialist Health Visitors, these cases were the aged ill patients, needing daily nursing care, male patients requiring bathing by the Male Auxiliaries and diabetic cases (for instruction and supervision in giving their own Insulin).

Midwives – 10 cases.

Personal applications – 41 cases. These cases come through worried and anxious relatives, they call requiring sick room equipment and seeking advice, invariably they have not liked to ask for the help of a nurse, and in many cases of incontinency bedsores have developed before we attend. Before visiting these patients – the family doctor is always informed.

The following detailed classification gives an interesting overall picture of the varying types of cases nursed during the year.

	Classification of cases	Patients	Visits
1.	Infectious Diseases		
	A. Pulmonary T.B.	35	1,733
	B. Other forms T.B.	6	354
	C. Pneumonia (not Broncho)	20	127
	D. Other infections	11	72
2.	Cancer		
	A. Medical	112	3,567
	B. Surgical	28	924

	Classification of cases	Patients	Visits
3.	A. Cardiac Diseases	185	6,320
	B. Stroke and Circulatory Diseases	136	4,564
4.	A. Bronchitis	159	1,861
	B. Respiratory Diseases	72	632
5.	Anaemia	266	6,144
6.	Diseases of the Central Nervous System	31	1,280
7.	Mental Illness	9	305
8.	Diabetes Mellitus	72	9,376
9.	Anaemia due to Pregnancy	97	951
10.	Complications of Pregnancy and Childbirth	16	149
11.	A. Other Medical	443	6,575
	B. Arthritis	58	2,728
	C. Kidney : Urinary Infection	9	54
	D. X-ray Investigations	201	231
12.	Other Aged	192	5,248
13.	Surgical Cases		
	A. Post Operative	146	2,842
	B. Ulcerated Legs	45	2,762
	C. Others	105	3,312
	TOTAL	2,454	62,111

AGED PATIENTS

Visits to the elderly patients have increased again this year, particularly to the male patients. With the help of Auxiliaries who work under the guidanc of the trained nurse, many of these visits are for rehabilitation purposes. Most of these aged patients live on their own, take to their beds and lose all interest in life ; constant encouragement is needed to get them up and dressed, in some circumstances a return visit in the late afternoon is required to help in putting them back to bed and ensuring they are comfortable for the night.

ANAEMIA OF PREGNANCY

Hope Hospital Ante-Natal Clinic has referred 90 cases of anaemia and pregnancy – these patients are usually unable to attend the hospital clinic because they have young children at home; they often need daily visits for Imferon therapy and find it difficult to organise someone to take charge in their absence.

DIABETIC PATIENTS

Visits remain high, but this is due to many patients being referred for instruction and supervision in administering their own Insulin.

AGE GROUPS

	Patients	Visits
0 – 5 years	50	349
5 – 14 ,,	46	206
15 – 39 ,,	340	4,218
40 – 64 ,,	741	17,156
65 – 74 ,,	536	16,472
75 years plus	741	23,710
	2,454	62,111

CARS

Three nurses use their own cars for work. This is most helpful and an asset – both in time saving and energy – it enables them to spare more time with their patients where needed, and to make distant calls in an emergency.

STAFF

Miss M. Thistlethwaite, Superintendent, resigned on December 31st, 1963.

Nursing Staff – once again there has been a considerable turnover of staff during the year, but fortunately vacancies on the establishment were soon filled.

		1st Jan. 1963			31st Dec. 1963	
Queens Nurses		7			6	
Student Queens Nurse		–			1	
State Registered Nurses	Full-time	4	6	Part-time	5	3½
	Part-time	4		Full-time	1	
State Enrolled Nurses	Full-time	5	5½	Part-time	1	5½
	Part-time	1		Full-time	5	
Nursing Auxiliaries	Full-time	3	4½	Part-time	3	4½
	Part-time	3		Full-time	3	
TOTAL			23			20½

New Appointments

Queens Nurse (1), State Registered Nurses (7), State Enrolled Nurse (1), Nursing Auxiliary (1).

Resignations

Queens Nurses (4), State Registered Nurses (4), Nursing Auxiliaries (1).

Queens Nurses

One left to take up a rural appointment in Wales; one married and has now moved to London; the other two left to return to hospital work.

State Registered Nurses

Three left for domestic reasons, and one left to return to hospital.

Nursing Auxiliary

Transferred to Health Visitors section.

Senior Nurses

Three Senior Nurses have been appointed from the existing staff. With the de-centralising of the Home Nursing Service in progress, these nurses will take on extra responsibilities; on them will depend the smooth running of a District Nurse Centre in an area of the City. Each will be the leader of a nursing team, the average number of staff will be six – this of course will

depend on the requirements of the area – the six may include: Queens Nurses, District Nurse Students, State Registered Nurses, Enrolled Nurse and Nursing Auxiliaries.

Other duties will include:

(1) Nursing of patients in their own homes,
(2) Reception and distribution of cases,
(3) Practical instruction of students,
(4) Loans service of sick-room equipment stored at Centre,
(5) Record keeping.

The Senior Nurse will work under the direction of the Superintendent.

DISTRICT NURSE TRAINING

Two students and one independent student from Canada were successful in passing the examination for the Queens Role and National Certificate in District Nursing.

COMMUNITY NURSING COURSE: MANCHESTER UNIVERSITY

The two students who gained part of their practical training and experience in the Salford Home Nursing Service returned for their final assessment, and both were successful in passing the examination for the Queens Role, We participated again this year in the practical training of two more students, they will return to Salford to take their final assessment. These students have enjoyed their training time in Salford, and feel the experience gained will be invaluable to them in the future.

REGENT ROAD

The evening clinic held at Regent Road between 5 and 6 p.m. has proved very successful for the people who are at work during the day – most of them call on their way from work for their treatments. The number of visits made to the clinic in 1963 was 1,205.

LATE VISITS

The number of patients referred in this part of the service have increased. The relatives look forward to the visit from the nurse at night to re-assure them, and they are so relieved when the very ill person is made comfortable and the pain-relieving drug is administered.

MURRAY STREET CLINIC

The first venture of de-centralising the Home Nursing Service commenced at Murray Street. The District Nurses now have a centre at these premises; it is proving to be successful and runs smoothly under the guidance of a Senior Queens Nurse and her team. This centre covers the following areas: St. Matthias Ward, Albert Park Ward, and parts of Kersal. Sickroom equipment is available at this centre for the use of the areas covered.

LANGWORTHY CLINIC

Accommodation has been placed at the disposal of the Home Nursing Service; we await the necessary constructional alterations to proceed with our third centre, which will cover the areas of Weaste, Seedley, Irlams o'th' Height, Eccles Old Road, Eccles New Road and Langworthy.

REGENT ROAD CENTRE

At the moment the greater part of the Nursing Staff is centred in this building. It is still the main centre for storage and cleansing of sickroom equipment.

KERSAL CLINIC

Two nurses work from a small sub-centre; they cover Lower Kersal and Charlestown areas – this cuts down a lot of travelling time.

CARE AND AFTER-CARE EQUIPMENT

Consisting of wheel chairs, commodes, beds, Dunlopillo mattresses, walking aids, hoists and lifting poles, plus many other items – which require plenty of space for storage – are still stored at Regent Road. This equipment is a valuable asset to the nurses in their work and is constantly in demand. Wheel chairs have proved to be very useful – and people with elderly, house-bound relatives are most grateful for the loan and delighted to be able to take the handicapped person out.

MARIE CURIE MEMORIAL FOUNDATION

The Marie Curie Memorial Foundation was established to help patients suffering from cancer, in a variety of ways – it is an independent organisation maintaining its services entirely by voluntary contributions.

In addition to various forms of residential help the Marie Curie Foundation has organised two schemes; one of these consists of a special nursing service provided through the agency of the local authority Home Nursing Service; the other scheme provides welfare grants to cancer sufferers in financial difficulties.

Arrangements have been made in the Salford Home Nursing Service to participate in both of these schemes.

Naturally in the case of Salford, day nursing care is covered by regular visits of the District Nurses.

A Night Nursing Service has now been established, consisting of one State Registered Nurse, one Auxiliary and two night-sitters. The cost of nurses' remuneration, uniform and travelling expenses, as well as any other expenses incurred, are covered by the Foundation according to the terms of the scheme. Already six cases have benefited from this scheme, and expressions of gratitude have been received from relatives.

The purpose of the Welfare Grant Scheme is to meet the urgent needs of cancer patients who cannot meet them out of their own resources; the main

stipulation is that cash must not be handed to the patients or their families. Purchases for the well-being of the patient can be made at the discretion of the Superintendent of Home Nursing. They include items of invalid diet such as milk, eggs, chicken, essences, fruit juices, etc. urgently needed clothing, and specialised nursing equipment not obtainable through the National Health Service. All of these essential purchases are paid for by the Marie Curie Foundation.

CHIROPODY SERVICE

During 1963 the demand for treatment by the old peoples chiropody service showed no signs of abatement. As can be seen by the figures covering the the years from 1960, there has been a consistent substantial influx of new patients seeking treatment. These new patients are referred to the department by a variety of sources such as, Family Doctors, Hospital Diabetic and Orthopaedic Clinics, the Cripples Aid Society, the Salford Civic Welfare, the W.V.S., the National Assistance Board, and the many other sections of the Health Department such as Home Helps, Health Visitors, District Nurses and Nursing Auxiliaries.

If we add the number of new patients referred since 1960 to the original number on the register at that time, it will be seen that 3,995 individual patients have been receiving treatment in the chiropody clinics, which is roughly one in five of the aged population of Salford.

It is worthy of note that over 800 new patients have applied for treatment during the year.

Comparative figures 1960-1963 inclusive

	1960	1961	1962	1963
Total number treated at home	563	1,177	1,659	1,857
Total number treated in clinics	3,586	5,173	5,563	5,812
Total number of treatments given	4,149	6,350	7,222	7,669
Total number of domiciliary cases	184	257	367	432
Total number of sitting car cases	212	249	260	292
Total number of walking cases	993	1,224	1,600	1,851
Total number on register at December 31st	1,389	1,730	2,227	2,575
Total number of patients referred during year	–	663	1,059	884
Percentage of appointments kept	85.74%	85.76%	87.2%	87.0%

When the number of privately practising chiropodists in the City is taken into account and the fact that there is also a Foot Hospital in Salford is considered, it must be acknowledged that the numbers attending the clinics prove the service to be both needed and worthwhile.

Another significant point is the fact that since 1960 the number of domiciliary patients has increased by about 135%, whereas the number of sitting car patients has only increased by 38%, this is no doubt due to the fact that there are only three sitting car sessions per week, and because many of the referrals are of a rather urgent nature it is more advisable to visit them at home than to wait for a vacancy in the sitting car list.

Many of the 427 emergency cases treated were referred to the clinics

for treatment by their Family Doctor who had sent them directly from his surgery to the clinic with some painful lesion. In these cases as in any other case which is causing the patient discomfort, the patient is seen to immediately without having to await a formal invitation to attend the clinic.

The consistency with which new patients continue to be referred must mean that the service will have to be expanded at a rate equal to the growth in the number of patients on the list and although at the present time the number of sessions being worked is sufficient to cope with the 2,575 patients on the register, if the pattern of expansion continues a greater number of sessions will ultimately be needed to keep pace with the demand.

The new Kersal Centre continues to be a busy clinic and has proved most popular with the patients who live in that area, and to keep up with the demand for treatment at this clinic a further session has had to be arranged. Many patients who had previously had to travel the long distances from the Kersal area to the Langworthy Centre and Murray Street Clinic are very grateful for the services provided at the Kersal Centre.

The Kersal Centre has also made a great contribution in easing the sitting car service for bringing the semi-ambulant patients to the clinics. Previously the sitting car had, in many instances, to carry patients from the Higher Broughton area across to Langworthy Centre; but now all patients in Salford 7, and 8, and parts of Salford 6 and 3, can be brought to the Kersal Centre with the consequent saving in time and mileage. Murray Street Clinic would not have been practicable for use by sitting car patients because of the difficulty in negotiating the steps by these aged and handicapped people.

The use of the Kersal Centre also means that many patients from this area who previously needed the sitting car to convey them to the Langworthy Centre can now dispense with transport and undertake the much lesser distance to the Kersal Centre on foot.

STATISTICS

Treated at clinics	Male	841 (10.9%)	
Treated at clinics	Female	4,971 (64.8%)	5,812
Treated at home	Male	285 (3.7%)	
Treated at home	Female	1,572 (20.5%)	1,857
	Total number of treatments given		7,669

Langworthy Road Clinic

Walking cases	Male	365	
Walking cases	Female	1,963	
Sitting car cases	Male	58	
Sitting car cases	Female	573	2,959

Regent Road Clinic

Walking cases	Male	187	
Walking cases	Female	1,105	1,292

Murray Street Clinic

Walking cases	Male	125	
Walking cases	Female	703	828

Kersal Centre

Walking cases	Male	101	
Walking cases	Female	551	
Sitting car cases	Male	5	
Sitting car cases	Female	76	733

Total number of patients on register at 31st December, 1963

Number of walking cases	– (71.88%)	1,851
Number of sitting car cases	– (11.33%)	292
Number of domiciliary cases	– (16.77%)	432
		2,575

Total number of patients invited to clinics during 1963 – 5,940

	Invited	Attended	Defaulted
Langworthy	2,967	2,613	354
Regent	1,259	1,133	126
Murray Street	984	770	214
Kersal Centre	730	660	70
	5,940	5,176 (87%)	764 (12.86%)

Total number of patients attended per invitation – 5,176

Additional cases treated

Emergency	427	
Redressings	206	
Observation	3	
	636	636

Total number attended 5,812

Number of clinic sessions held during 1963

Langworthy	429 Day	
	34 Evening	463
Regent	143 Day	
	46 Evening	189
Murray Street	144 Day	144
Kersal Centre	95 Day	
	15 Evening	110

Total number of chiropody clinic sessions held – 906

HOME HELP SERVICE

The exceptionally severe weather conditions of the first months of 1963 caused a considerable strain on the resources of the service and emphasised the need for considerable extension of the Home Help Service. Whilst large numbers of elderly persons manage quite well with one weekly visit from a home help during warm weather, the vast majority would benefit from additional help during hazardous weather conditions. Shopping becomes a nightmare round the streets where ice and snow remain longer than on busy main roads and the intolerance to cold, which is part of the ageing process, inflicted distress in numerous households. Home Helps spent much time carrying water and getting pipes thawed out, though there were several tragic cases of illness and discomfort caused by the weather, it is true to say that dozens of old people would not have been able to remain in their own homes without the help and support of their Home Helps. Unfortunately, it is never possible to serve every case each week, and throughout the year there have been over 100 households each week for whom there was no help. Careful re-adjustment of hours and the moving of helps to cases of urgent need did spread the available help as widely as possible.

The appointment of additional field workers and the provision of transport would do much to ensure that help is never retained longer than necessary and the time of Home Helps used more effectively. Indeed, if an increase does not take place very shortly a serious position will arise, as new referrals and periodical visits take up all the time of the assistant organisers. Supervisory and supportive visits to Home Helps during their working hours can do very much to encourage 'esprit de corps' and general efficiency of the service.

The following figures show an increase of 134 in the total of households assisted in 1963 as compared with the previous year.

Cases for whom help was provided during the year:—

Aged 65 and over	1,614
Chronic sick and T.B.	182
Mentally disordered	15
Maternity	65
Others	53
	1,929

A total of 841 requests for help were made and 624 were accepted as being in need of assistance from Home Helps.

During the year the Superintendent of District Nurses and the Home Help Organiser consulted frequently concerning cases, and often arrangements were made to co-ordinate visits from nurses and Home Helps in order to provide maximum attention for patients. District Nurses attended 283 cases where Home Helps were also in attendance.

Sources of Application (expressed in percentages):—

Health Visitors	29.96
Self	15.58
Hospital Almoners	12.84
General Practitioners	10.46
Relatives	6.90
Friends	5.23
National Assistance Board	5.11
District Nurses	4.28
Welfare Officers	3.45
Cripples Help Society	2.74
Mental Health Officers	2.02
Midwives	1.43

FAMILY HELP

Most of the Home Helps appreciate an occasional change from dealing with elderly people, and where requests were received to take over a home because of the illness of the mother it was possible to provide very good service. One is aware that considerably more work could be done in this field to the benefit of the families, as often husbands stay at home with consequent loss of earnings during periods when wives are ill or in hospital. Unfortunatley, help is not sought because of fear of a high charge being made or a reluctance to reveal deficiencies in domestic equipment and facilities.

Possibly effective co-operation between all field workers in the Health, Children and Civic Welfare Departments in relation to the provisions of the Children and Young Persons' Act, 1963 will result in Home Helps being used to assist in alleviating distressing family situations. The attendance of a capable Home Help who can show an inadequate mother how to achieve a better standard of home and mother-craft can be of great assistance to the primary social worker in families subject to strain. The provision of material aid and the allocation of Home Help service might often prove a happier solution than removing children 'into care'.

MATERNITY CASES

Obviously the only way to encourage greater use of Home Helps during confinements would be the abandonment of charges in such cases or the adoption of a system whereby the weekly Home Confinement Grant became the standard charge for every mother. The midwives in the city often perform their tasks in conditions of great difficulty. So often it seems a pity that they cannot be certain of adequate domestic arrangements in the homes of their patients. During the year 90 applications for help in maternity cases were made; usually on the advice of the midwife; 65 cases were given service as the remaining 25 did not proceed with their original request for assistance.

CHARGES FOR SERVICE

Summary of Payment for service :–

	Free	*Part Cost*	*Full Cost*
Aged 65 years or over	1,378	219	17
Chronic Sick and Tuberculous	128	48	6
Mentally disordered	15	–	–
Maternity	13	40	12
Others	18	30	5
Totals	1,552	337	40

STAFF

Recruitment of Home Helps was assisted by the redundancy of part-time women workers at some local factories. Not all who applied were considered suitable for the work which demands high standards of efficiency, integrity and sympathy as well as competance in housecraft. Home Helps generally have to work with the barest minimum of equipment and often old people do not provide sufficient cleaning powders and polishes. Quite a number of old people have been rehoused and it is a tremendous encouragement for Home Helps to be working in modern houses and flats, as homes with no hot water system and old and broken fittings are a danger to both health and morale. A new style of overall was issued to replace the old fashioned blue drill type and the pleasant apple-green nylon coats have been very much appreciated. A badge was also issued both as a mark of identity and to encourage 'esprit de corps'. The Civic Badge of the City was suitably adapted and the design executed by a member of the Ambulance Service who is a skilled artist.

The administrative staff remained constant and the two social workers were re-designated as Assistant Home Help Organisers. Special tribute is due to these officers in respect of their excellent record of service, with very little time off in respect of sick leave over a period of many years.

The Training Course continued to be held at the Salford Technical College and successful students received their certificates from the Deputy Chairman of the Health Committee at a pleasing ceremony in the Mayor's Parlour.

Number of Home Helps employed end of December	266
Number of Home Helps who terminated employment during year	81

Reasons for leaving were as follows :–

Ill Health	34
Other Employment	15
Domestic Reasons	15
Found work unsuitable	12
Retired	2
Removed	1
Pregnancy	1
Dismissed	1

NIGHT SITTING

Although only ten cases were supplied with this service it proved of

inestimable help to tired and anxious relatives caring for very sick people. When ever possible families are persuaded to accept a Home Help during the day whilst they rest, but in some instances service is also required during the night.

The Home Help Service must expand and operate with a great deal of flexibility if the community is to secure maximum benefit. Co-operation with all health and social agencies is very essential and thanks are due to many individual officers throughout the City who have kept the service informed of developments in cases of mutual interest. The Service is also very well supported by the efficiency of the clerical staff dealing with wages, records and accounts.

MENTAL HEALTH SERVICE

GENERAL REVIEW

(M. W. SUSSER, *Medical Officer for Mental Health*)

SUMMARY

The need is stressed for eliminating delay in development. Over the next decade an increment of cases of severe subnormality is to be expected at the rate of 3.5 per 100,000 population each year. This will further increase pressure on hospital care, and an experiment of decentralised community care is advocated for Salford. Effective integration of local services for the subnormal has been achieved, and is reflected by the early age of notification of the majority of cases.

In mental illness there seems to be some shift back towards more hospital care and more compulsion.

Developments in residential and day care continue slowly; new day groups have started, purpose built centres are in prospect, and efforts are being made to develop new forms of residential care. There is an increase in the number of social work contacts made for each referral and social workers also participated in research interviewing. Research in progress is summarised.

* * * * *

Previous Salford reports have been concerned to show both the development and the problems of a community mental health service. Progress has been continuous and the City ranks high in its mental health provisions compared with other authorities, despite its lack of rich rating areas. Nowhere is there a better ratio of mental welfare officers to total population and the statistical analysis presented in the last annual report (for 1962) demonstrated a great shift of work from hospital to community. Even in the absence of comparable statistics for other areas, there is little doubt that as much work is done outside the hospital in Salford as anywhere in the country. In the field of subnormality the low rate of hospital admission from Salford does not conceal a low rate of ascertainment of persons in need of care, as studies show it may do elsewhere; the low rate follows from a high provision of community care in a fully ascertained population.

All this is creditable, but it is a small beginning in the attempt to meet obligations and standards in the care of mental disorder suitable to a civilised community. In all spheres the work cannot develop because of lack of accommodation, and the accommodation that is available is often quite unsuited to its purpose. To bring about obviously needed change takes many years, until all come to accept interminable delays with complacency. The rate of change in contemporary society is so great that the most rapid development can only meet the needs of yesterday; delay puts development out of date before it starts.

This is certainly the position throughout the country in the care of

patients with mental disorder. In all branches of the health service we are dealing only with the most obvious and pressing problems. Surveys repeatedly show the large numbers of old people who live handicapped by mental confusion and mental illness without a minimum of care. Many mental problems beset people during their early lives also and go unrecognised or unhelped. Some of these appear to be intractable. Others are tractable and we know what might be done but few can set their sights so high as to hope for services which can do, within one, two or three years, all that is already possible.

In order to achieve targets for adequate care, public health must redirect its efforts. The need is for officers with special fields of interest who can conduct research and develop plans on the basis of that research. Such officers require guidance in research methods; in Salford we are fortunate to be moving in this direction through our connection with the Manchester University Department of Social and Preventive Medicine. The mental health service in particular has benefited from this type of arrangement, beginning with the appointment of a Medical Officer for Mental Health (M. W. Susser) who was a member of the University department. Later a second appointment was made (A. Kushlick). In addition members of the Department of Education in the University have been able to take up appointments as advisers to the training centres.

These appointments have led to a close and critical examination of the work of the mental health service, and needs have been discovered and underlined. New facilities have been developed as a result, but it remains to bring many others into being. The delays in providing facilities seem to demand reform which goes beyond the medical level and involves the administrative process in higher echelons.

STATISTICAL TRENDS IN SUBNORMALITY

The data collected and analysed on this service by Dr. A. Kushlick (who has left us to take up a unique appointment to do research into services for the subnormal with the Wessex Regional Hospital Board) shows that if the trends of the previous decade continue we may expect an increase in the severely subnormal population. From further work by Dr. T. Fryers, we predict an annual net increment of 5.5 in the total population.

This figure is derived from a comparison of the register of subnormality in Salford at 1st January, 1961 with the register reconstructed for 1st January, 1948 (see annual report 1960 – appendix III). The register at 1st January, 1961 comprised 351 cases and the prevalence figure was 2.34; at 1st January, 1948 it comprised 262 cases and the prevalence figure was 1.47 In a population of approximately 150,000 as now in Salford this rate of change would lead to an increase in the next decade of 68 cases. In Salford, however the population has been declining. The actual increase in cases was 71 over the 13 years. An estimate for the next decade made on the assumption of a declining population continuing at the same rate gives an expected increase of 55 cases (or 5.5 per annum) over and above the 349 cases (excluding 17 as yet unclassified) on the register at 1st January, 1964.

Despite the increase in the number of cases of severe subnormality in the community there is reason to believe that fresh cases are occurring less

frequently than before and that the increase is due to survival to later ages. The increasing age of the severely subnormal population is demonstrated in Table 1 which compares the ages of the severely subnormal populations on the register on 1st January, 1948 and 1st January, 1961.

Table 1A

Age Distribution: Percentage of total of Severely Subnormal on Register by 10-year age-groups

	AGE GROUP							
	0-9	10-19	20-29	30-39	40-49	50-59	60-69	Unknown
1st Jan 1948	8.0	25.2	27.5	22.9	9.5	3.8	2.3	0.8
1st Jan 1961	10.0	20.4	19.2	21.2	14.8	10.3	3.2	0.9

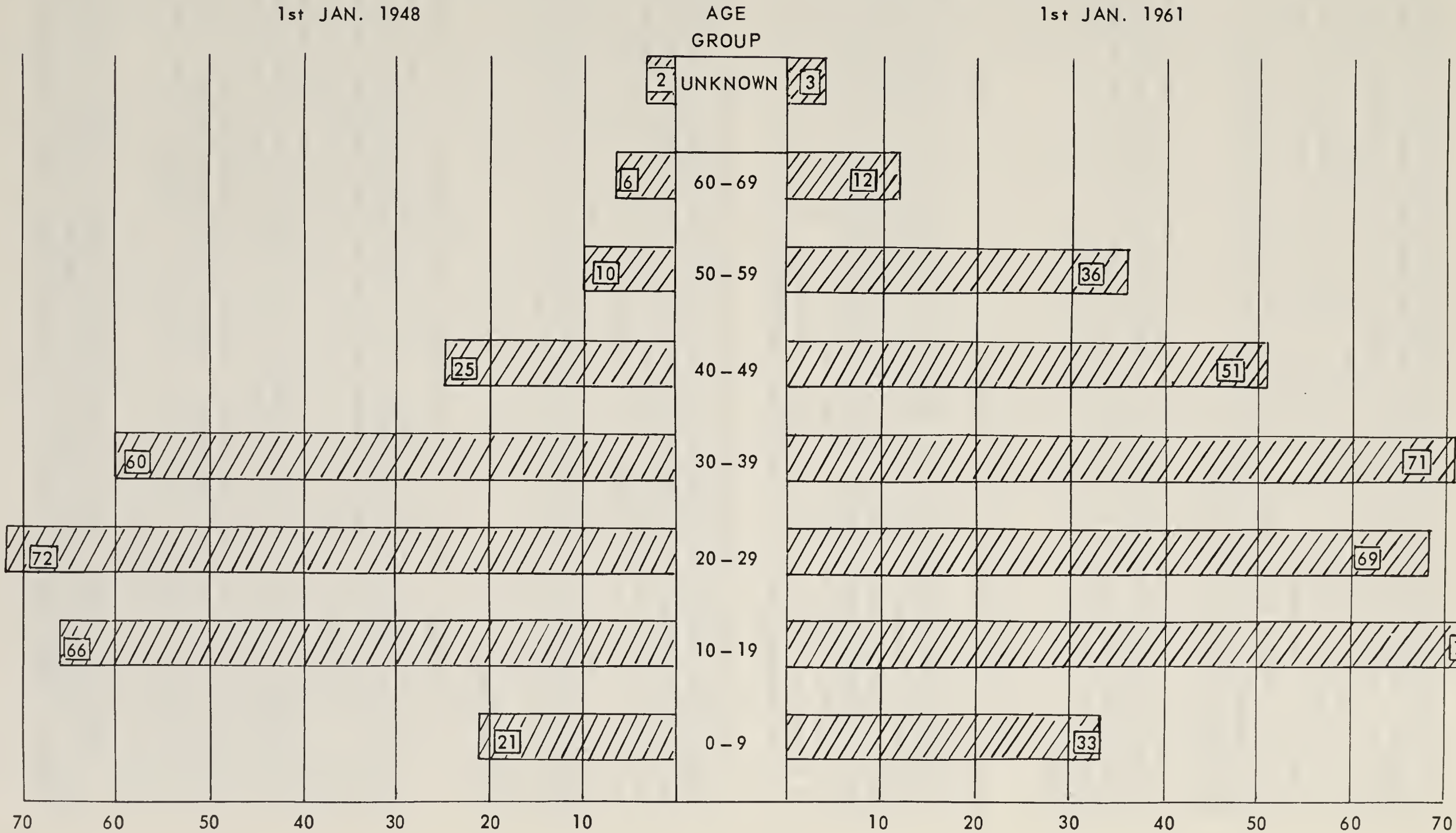
Table 1B

Age Specific Rates per 100,000 by 10 Year Age Groups

	AGE GROUP							Total
	0-9	10-19	20-29	30-39	40-49	50-59	60-69	Population
1st Jan. 1948	70	290	270	221	96	49	39	147
1st Jan. 1961	140	283	330	366	238	165	75	219

Table 1C

Numbers of Severely Subnormal by 10 Year Age Groups



The accumulation of cases in the higher age groups can be expected to continue until increasing survival and decreasing incidence come into balance; stability may well follow at a stage when the subnormal population as a whole has aged considerably. The process is likely to resemble that of developing economies in which the population increase from improved survival is accompanied by declining birth rates, until the population stabilises with a much higher proportion of adults and old people. (In Salford the picture is complicated by migration from the City, which varies between age groups and social classes).

In the face of this phenomenon of population increase among the subnormal it behoves us seriously to consider future arrangements for their care. In many areas there is an increasing pressure for admission to hospitals which are already groaning under long waiting lists for the severely subnormal.

More than half (180) of the 351 severely subnormal cases on the register on 1st January, 1961 were in hospitals.

Long term admissions to hospital from Salford over the period 1948 to 1963 have averaged 4.7 per year. This is a low rate for the region according to the analyses of J. Leeson for the Manchester Regional Hospital Board, and A. Kuslick notes that it is less than half the rates for London, Leeds and Wessex. Thus in Salford we may expect that the main build-up of cases of severe subnormality will be in the community. On the other hand, we may only be damming back the demand for residential care.

In any event new facilities for both young and old become a matter of urgency. In Salford we hope to bring into effect our plans for exploring the possibilities of local community care to the full (see Annual Reports for 1960 and 1962.) In this endeavour financial assistance will be required in the provision of residential care and in evaluating the project. Salford would provide an excellent testing ground for the experiment, since the nucleus of the necessary services such as hostels and day centres are already available, and the work of hospitals and local health authority is well co-ordinated.

1963 Admissions:

It is relevant to note a marked increase in admissions to hospitals for the subnormal during 1963. (Appendix VIII). We believe it is connected with a significant change in relationships since the Mental Health Act came into effect, between the community mental health service and hospitals for the subnormal. Community workers have become aware that admission for a subnormal patient with behaviour problems is no longer the equivalent of an indeterminate sentence and a formidable last resort. The interest of hospital staff in arranging the discharge of their patients has helped to stimulate this awareness, and hospital admission can now be regarded as a temporary expedient for many. Reorganisation towards therapeutic ends is under way in a number of hospitals. When these reforms are fully effective admissions may increase yet further.

However, hostel care with good local facilities in day centres would have sufficed for the large majority of the patients admitted. 13 of the 19 were of medium grade; in 8 of the 13 the chief need was for residential care

in the absence of effective kin support. They did not enter the Salford hostels because they did not meet our criterion that the patient should be a potential candidate, however remotely, for employment.

AGE AT NOTIFICATION

Perhaps the most notable development in care for the subnormal is the shift in age of notification; few cases are now notified at school leaving age and there is a great advance in early notification of cases (Appendix VIB). This has made a reality of our longstanding aim of starting work with the family from the earliest moment in order to provide maximum development of the child and prevent subsequent social and emotional maladjustment in the family (see Dr. Mackay's report, page 159 and Annual Reports for 1960 and 1962.) Two thirds of notifications to the mental health service are made before 5 years of age. This has been made possible by the close integration of paediatric, maternity and child welfare, and mental health services in Salford.

The Mental Health Act is responsible for the fact that the number of subnormal school leavers of high grade now notified is so small (Appendix VIB). This need not concern us, provided that education authorities take on the responsibility of continuing the schooling of such persons with the same vigour as they do for grammar school children. This is the proper provision for their needs, which arise chiefly from their lack of intellectual and social maturity.

STATISTICAL TRENDS IN MENTAL ILLNESS

The Salford Mental Illness study shows that the number of patients presenting to a psychiatric agency for the first time has not varied much over the past 5 years, nor on the whole have their attributes of age, sex, social class and diagnosis. A comprehensive analysis and tabulation is given in the report on page 146 and its appendices.

There has been a steady increase in new patients referred to the mental health services however, and this is the chief cause of the rising trend of notifications (Appendix VA) to the service. General practice is the main source of the increase of referrals (Appendix I). Contrary to expectations direct admissions to mental hospital by general practitioners (a procedure which has been possible for the past three years) show a fall in 1963.

The steady falling trend of hospital admissions since 1956 (when Springfield Hospital became the main mental hospital for Salford) came to an abrupt end in 1963, and the admission rates again resemble those of 1961 (Appendix III). For the first time as well, the trend towards voluntary admissions has been halted and compulsory admissions rose, especially for males. As we have argued in previous reports, the particular instrument used in admitting patients is more than a matter of convenience. It reflects the attitudes of the professional worker towards his patients, and in psychiatry these are of fundamental importance to the quality of work. All the workers involved ought carefully to examine their procedures in the light of this. Although it could be a handicap that the arrangements under the Mental Health Act actually provide a financial incentive to compulsory admissions, there is no evidence that this has played a part in the change. We cannot fully comprehend the significance of the increase in admissions to mental

hospital until we also analyse the duration of stay and the precise characteristics of the patients admitted. We have, however, examined the number of discharges and these also are the lowest for the period since 1956. In addition to the increase in admissions to mental hospital there has been an increase in admissions to newly provided psychiatric beds in the general hospital. As yet we have not studied the characteristics of patients admitted to the general hospital, but they possibly represent a different segment of the mentally ill population from those usually admitted to mental hospitals.

The increase in the use of services is general to the psychiatric agencies in Salford as a whole over the past few years. Up to 1962 the trend was towards a declining use of the mental hospital and an increasing use of out-patient and local authority facilities. During 1963 use of the local authority facilities continued to rise as before, but the balance between out-patient and in-patient hospital care shifted towards in-patient care. (Appendix IV).

COMMUNITY FACILITIES

Despite our snail's pace in such matters as building suitable centres, development has taken place during the past year.

Hostels and Residential Care

Analysis of hostel placements shows that the hostels are not being used to the full. Some of this is unavoidable; fuller occupancy can easily be achieved, however, by the acceptance of a larger proportion of residents who are likely to stay for long periods.

Our tables (Appendix XIA) show that the main *reasons for admission* to the hostels were lack of home (especially among women), the need for a halfway house in transition from hospital to community (especially among men) and the need for a protected environment, alternative to hospital, in partially dependent persons.

The *outcome of placements* was satisfactory (in the sense that the placements went according to plan) in 65% of all cases, but women were more amenable than men, and older patients than young ones. (Appendix XID). Outcome also varied by diagnosis; severely subnormal patients were the most amenable, then the high grade subnormal and then psychotic patients; the least amenable were neurotic and psychiatric patients. (Appendix XIF). The difficulties of staff with the group of young patients with behaviour disorders should not obscure the fact that there have been a number of successes among them.

An attempt has been made to introduce a greater element of responsibility and initiative among hostel residents by starting a house committee with certain duties and disiplinary responsibilities. Little success has been achieved so far, partly because of the lack of persons among the patients with experience and qualities of leadership. Efforts to promote this development continue.

We have not yet been able to initiate experiments of other forms of residential care in the community, such as boarding out and setting up small households of patients, but efforts to do so continue.

Day Care

A rehabilitation work group has been started for those patients who fit into the category of mental illness or of high grade subnormality with behaviou

disorders, and who do not assimilate well to our existing adult training centres (which cater chiefly for subnormal persons). In the absence of other accommodation the group began with gardening at Kersal Hostel ; since then it has moved into some dilapidated premises at Acton Square, near the Crescent Centre, which the group itself is renovating; finally it will move to Cleveland Day Centre.

Two rooms additional to the one in use have become available at the Cleveland Centre. This will make it possible in the course of the next year to diversify the centre ; in activities by adding industrial and domestic training and group discussion to occupation therapy ; in membership by adding men and a wider range of ages to the present predominantly middle-aged and elderly group of women; and in staff by bringing assistance to Miss Williams who for so long has maintained the centre more or less singlehanded.

In centres for the subnormal speech therapy and physiotherapy are available to the children and the remedial teaching programme continues (see page 156). The new junior centre for the subnormal is impatiently awaited, since planning began in 1959. Planning for a new adult centre has also begun and at the time of writing a site has been selected. Mr. H. Thornley, newly appointed as Senior Administrative Mental Welfare Officer, has obtained industrial contracts for the adult centres sufficient to keep them continuously active.

Social Work

In the matter of social work special effort has been made to encourage continuity of care and longer follow-up of individual cases. Follow-up work presses less urgently on the mental welfare officers than does that of fresh referrals. In order to relieve the officers from the continual distraction of referrals, and to improve follow-up, and to allow them to take up special interests or duties, the system by which each mental welfare officer has his own panel of general practitioners has been modified. The officers are now paired so that each officer has a substitute who can stand in for him while he carries out work that does not present as an emergency.

These arrangements have enabled social workers to participate directly in research interviews and this they have done in three separate projects. During the year visits were completed on a consecutive series of patients from Salford who came into the purview of any psychiatric agency. These visits provided important additional material for the Salford Mental Illness survey. An exploratory study was also made of the attitudes of relatives of patients admitted to hospital towards the patient and towards the services. Relatives of a consecutive series of patients were routinely visited during the third week of the patient's stay in hospital. Plans were also made to conduct a pilot follow-up study (see page 146). A good deal of preparation was devoted to this so that the mental welfare officers would have a good command of the techniques they were to employ and so that they could contribute to the planning.

Social work in this country lacks measures of its operation. Although for some years in Salford we have analysed the case load in terms of

visits (Appendix VA and B), we know little about the details of these visits. The P.E.P. survey of mental health services included Salford and their analysis of social work has added to our knowledge of the field and shown that the range of social work tends to be circumscribed by the social worker's situation. Thus workers in the community deal with a wider range of problems than those in hospital. In Salford we have now devised a system of recording, to go into operation for 1964, which will provide more details of the nature of social work in a mental health department.

One large contribution to the efficiency of social work would be an increase in office interviewing. The new offices of the health department – which in most respects are a great improvement – do not permit this because of the entire lack of soundproofing. Until acoustics are improved the privacy needed for office interviewing is not available.

The taking on of social work students for practical work from the Younghusband Course has been a stimulus but also an important additional commitment. *The statistics on the case load,* however, show a welcome increase in the total number of visits and in the number of contacts per referral. Each patient gets more visits, although there is some decline in the number of visits made by each social worker (Appendix VA and B).

SOME PRELIMINARY RESULTS OF THE SURVEY OF MENTAL SICKNESS IN SALFORD

(Zena Stein,* *M.R.C. Research Fellow, Department of Social and Preventive Medicine, Manchester University)*

Since 1959 we have retained records of all Salford residents who have come into the care of psychiatric agencies, whether it be the mental health service, the mental hospital, or the psychiatric wards and out-patient departments of the general hospitals. From these records we have information relating to :–

(i) The number of fresh cases (or inceptions) of mental disorder i.e., the first episode to bring the patient into contact with any psychiatric agency.

(ii) The number of relapses or repeat episodes.

(iii) The services called into action at each episode.

THE AMOUNT OF SICKNESS

1. Fresh Cases

Tables I, II and III show that there were on average 382 fresh cases

*The team working on this survey also includes A.M. Adelstein and M.W. Susser, and D. Downham (on an M.R.C. grant) has worked on the processing of the data on the Atlas Computer. Mrs. M. Malloy, Mrs. R. Wingate and Mrs. P. Ridyard have successively given technical assistance.

of mental sickness each year in the Salford population (155,090 at the 1961 Census). About 35 were cases of schizophrenia, 110 of depressive psychosis, and 41 senile psychosis; the remaining 195 were cases of neurosis, psychopathy, addiction, organic mental disorders and miscellaneous conditions.

More fresh cases occurred in women than in men, and more arose in those under 40 in both sexes than in the older age groups. According to the rates, the risk was higher for those under 40 and over 60; single and divorced persons were more often subject to attacks than were the married, and for men at least, there was an over-representation of the unskilled labouring classes.

2. Episodes

Tables IV, V and VI show that there were on average 905 episodes of mental sickness in Salford per year, that is, nearly two and a half times the number of fresh episodes.

194 of these episodes were in schizophrenic patients, 259 in patients with depressive psychoses and 71 in the senile; the remaining 381 were psychoneurotic, psychopathic, organic and miscellaneous episodes.

3. Service Usage

Table VII shows that each service dealt with a different range of illness. The mental hospital dealt mainly with schizophrenia—55% of all schizophrenic episodes were admitted—and with depressive psychoses, of which about one third were admitted. About half the senile were admitted but only a quarter or less of the remaining diagnostic groups.

The out-patient clinics and the general hospitals served a fair number (about one third to half) of the episodes of depressive psychoses and the majority of the non-psychotic episodes.

The mental health service was the most diverse in the diagnostic categories served, and numerically was the major agency. Most of the mental hospital admissions and one fifth of the out-patient consultations were channelled into these services by the mental health department.

SOCIAL FACTORS IN MENTAL ILLNESS

In studying the relationships between inception of illnesses, relapse, and the use of services we posed two questions:—

(i) *Is it clinical condition alone that determines the selection of a particular service in an individual case? or are there social factors that influence the selection and if so, in what ways do they operate.*

(ii) *Do social factors influence the chronicity of an illness (as measured by the number of episodes) once it is established?*

1. Selective Use of Services

(i) The proportion of all episodes admitted rises with age for both men and women. Depressive illness makes the main contribution to the differences; in schizophrenia about the same proportion is admitted to mental hospital at all ages. (Table viii).

(ii) In any given episode of mental illness, those most often admitted to mental hospital are widowed and divorced men. (Table ix).

(iii) The proportion of admissions for all episodes of mental illness rises from social classes 1 to 5 but the rise is particularly marked with schizophrenia. (Table x).

There may be several reasons for these differences in admissions. To take the example of schizophrenia, cases occurring in the lower social classes may need admission because their clinical condition is more severe, or they may lack adequate support in the community and therefore need admission; or there may be an unconscious tendency for workers in the psychiatric agencies to admit such patients.

These results show that it is not only the diagnosis that must be considered in studying the burden of mental illness on the community, for given a certain number of cases, for example of schizophrenia, the age, sex, social class and marital state of those living in the community will affect the number of admissions that will arise from a given number of episodes.

2. Social Factors and Chronicity

(i) Women are more prone to repeat episodes of psychotic mental illness than are men, and middle aged women are more prone than women of other ages. Young men with schizophrenia are the next most prone to relapse. (Table iv).

(ii) The divorced are more prone to relapses than are the single, married or widowed. (Table v).

(iii) Men from the manual labouring classes have more repeat episodes than other men. The difference is most marked for episodes diagnosed as schizophrenia. (Table vi).

(iv) On the whole, repetition of episodes exaggerates those differences between social groups which can be recognised in inception rates.

In the total pattern of episodes the divorced are more different from the married, and the unskilled are more different from the skilled manual and the non-manual, than in the pattern of inceptions alone.

These findings on the inception and repetition of episodes of mental sickness must be considered in interpreting prevalence: for instance in the recent major prevalence studies in the United States which confirm the association of mental impairment with poverty and social deterioration and instability. Prevalence is a measure of what exists at one point in time. It is the product of the incidence of disorder in any population and of its duration.

The *same* incidence of disorders of *short* duration will produce a prevalence that is low compared with those of *long* duration. Our results, while confirming that incidence varies between social groups, emphasise the contribution that chronicity and relapse may make to the difference in prevalence between these groups.

The prevention of mental illness in vulnerable groups therefore requires a two-pronged attack. *First*, in order to reduce the onset of such cases (expressed by inception rates), we must search for causes and precipitating factors to guide action. For this purpose we must pursue basic research into causes. *Second*, in order to reduce the relapse rate and prevent chronicity, we must experiment with therapeutic services to improve the prognosis of patients in the less favourable social positions. This requires expenditure on training and facilities. In both these fields there is a great deal to be done by community mental health services.

TABLE No. I

Inceptions of Mental Sickness by Diagnosis, Age and Sex
(Annual Average 1959-1962)

DIAGNOSIS

Male	Schizophrenia	Manic Depression	Senile Psychosis	All Other	Total	*Rates per million living
20 – 39	13	13	–	50	76	3,795
40 – 59	6	15	–	29	50	2,441
60 +	1	7	11	16	35	3,794
Total	20	35	11	95	161	3,248
Female						
20 – 39	8	30	–	58	96	4,954
40 – 59	5	29	–	30	64	2,948
60 +	2	16	30	12	60	3,851
Total	15	75	30	100	220	3,889

* 1961 Census.

TABLE II

Inceptions of Mental Sickness by Diagnosis, Sex and Marital State
(Annual Average 1959 – 1962)

DIAGNOSIS

Male	Schizophrenia	Manic Depression	Senile Psychosis	All Other	Total	*Rates per million living
Single	12	10	–	30	52	5,261
Married	6	22	7	59	94	2,536
Widowed	1	3	4	3	11	4,555
Divorced	1	–	–	1	2	3,768
Not Known	–	–	–	2	2	–
Total	20	35	11	95	161	3,248
Female						
Single	6	21	4	15	46	5,104
Married	7	39	6	78	130	3,520
Widowed	2	13	19	5	39	3,883
Divorced	–	1	1	1	3	5,390
Not Known	–	1	–	1	2	–
Total	15	75	30	100	220	3,889

* 1961 Census.

TABLE III

Inceptions of Mental Sickness by Diagnosis and Social Class (Men only)
(Annual Average 1959 – 1962)

Males	Schizophrenia	Manic Depression	Senile Psychosis	All Other	Total	*Rates per million living
I	Less than 1	Less than 1	–	Less than 1	(approx) 1	1,160
II	1	2	1	4	8	1,351
III	6	17	6	43	72	2,227
IV	2	5	1	11	19	1,920
V	6	7	2	19	34	2,644
Not Known	5	4	1	18	28	–
Total	20	35	11	95	162	2,612

* 1961 Census

TABLE IV

Episodes of Mental Sickness by Diagnosis, Sex and Age
(Annual Average 1959 – 1962)

DIAGNOSIS

Male	Schizophrenia	Episode Inception Ratio	Manic Depression	Episode Inception Ratio	Senile Psycho	Episode Inception Ratio	All Others	Episode Inception Ratio	Total	Episode Inception Ratio
20 – 39	65	5.21	27	2.0	–	–	93	1.86	185	2.43
40 – 59	30	5.22	34	2.19	–	–	70	2.41	134	2.65
60 +	4	3.31	15	2.18	20	1.82	24	1.5	63	1.8
Total	99	5.04	76	2.12	20	1.82	187	1.9	382	2.36
Female										
20 – 39	39	4.53	58	1.97	–	–	99	1.71	196	2.05
40 – 59	42	8.95	84	2.93	–	–	73	2.43	199	3.12
60 +	14	6.88	40	2.56	51	1.70	22	1.83	127	2.12
Total	95	6.2	183	2.47	51	1.70	194	1.94	523*	2.38

* 1 case, age unkown, added to total.

TABLE V

Episodes of Mental Sickness by Diagnosis and Marital State. (Annual Average 1959 – 1962)

and

Episode/Inception Ratio (Total Numbers 1959 – 1962)

Males	Schizophrenia	Episode Inception Ratio	Manic Depression	Episode Inception Ratio	Senile Psychoses	Episode Inception Ratio	All Others	Episode Inception Ratio	Total	Episode Inception Ratio
Single	61	4.88	20	2.08	1	2.5	62	2.07	144	2.74
Married	30	5.08	52	2.32	12	1.69	107	1.81	201	2.14
Widowed	3	3.67	3	1.08	7	1.63	8	2.67	21	1.95
Divorced	4	9.0	1	2.0	–	–	6	6.0	11	7.0
Not Known	1	–	–	1.0	–	–	4	2.0	5	2.0
Total	99	5.04	76	2.12	20	1.7	187	1.97	382	2.36
Females										
Single	32	5.52	33	1.57	10	2.28	43	2.87	118	2.57
Married	48	6.47	127	3.23	8	1.39	127	1.63	310	2.38
Widowed	11	6.14	20	1.59	32	1.67	20	4.0	83	2.12
Divorced	4	15.0	2	2.67	1	1.0	3	3.0	10	2.92
Not Known	–	–	1	2.0	–	1.0	1	1.0	2	2.2
Total	95	6.2	183	2.47	51	1.70	194	1.94	523	2.38

TABLE VI

Episodes of Mental Sickness by Diagnosis and Social Class (Men Only)

(Annual Average 1959 – 1962)

	Schizophrenia	Episode Inception Ratio	Manic Depression	Episode Inception Ratio	Senile Psychosis	Episode Inception Ratio	All Others	Episode Inception Ratio	Total	Episode Inception Ratio
I	1	–	–	–	–	–	1	1	2	2
II	3	3.5	4	2	2	1.4	9	2.25	18	2.2
III	31	4.8	34	1.9	11	1.8	79	1.84	155	2.2
IV	12	6.9	9	1.8	1	1.0	21	1.91	43	2.3
V	35	6.1	20	2.9	3	1.6	46	2.42	104	3.0
Not known	17	–	9	2.12	3	2.4	31	1.72	60	2.2
Total	99	5.0	76	2.12	20	1.82	187	1.9	382	2.36

TABLE VII

Use of services by Diagnosis, Sex and Age
(Annual Average number of episodes 1959-1962)

Males	Schizophrenia	Manic Depression	Senile Psychosis	All Other	Total
Total Episodes	99	76	20	187	382
Mental Hospital	51	22	12	44	129
*Peripheral Unit (in – out patient)	18	41	1	85	145
Private Psychiatrist	1	5	1	13	20
Mental Health Service and Mental Hospital	41	17	8	38	104
and Peripheral Unit	6	5	1	12	24
Alone*	29	8	6	45	88
Mental Health Service Total	76	30	15	95	216
% of Episodes admitted to Mental Hospital	50%	29%	59%	24%	34%
Females					
Total Episodes	95	183	51	194	523
Mental Hospital	51	64	25	33	173
*Peripheral Unit (in – out patient)	10	75	3	84	172
Private psychiatrist	2	10	1	20	33
Mental Health Service and Mental Hospital	47	53	21	32	153
and Peripheral Unit	5	14	3	10	32
Alone*	32	34	22	57	145
Mental Health Service Total	84	101	46	99	330
% of Episodes admitted to Mental Hospital	55%	37%	50%	17%	33%

*These figures are still subject to correction. In some instances a referral to the Mental Health Service and to the peripheral unit occurred simultaneously, and the allocations may yet be revised. In such episodes priority has been given to the Mental Health Service for the purposes of this Report.

TABLE VIII

Percentage of Episodes* associated with Mental Hospital Admission by Diagnosis, Sex and Age. (Annual Average 1959-1962).

Male	Schizophrenia	Manic Depression	Senile Psychosis	Psycho neurosis Psychopathy	Total
<40	50	19	–	20	32
40–60	57	33	–	34	41
60>	56	44	60	30	52
All	50	29	60	26	38
Female					
<40	62	25	–	14	31
40–60	57	42	–	24	40
60>	30	45	51	10	46
All	55	37	51	18	38

*Episodes other than those listed above have been excluded from this table.

TABLE IX

Percentage of Episodes* associated with Mental Hospital Admission by Diagnosis, Sex and Marital State. (Annual Average 1959 – 1962)

Males	Schizophrenia	Manic Depression	Senile Psychosis	Psycho neurosis Psychopathy	Total
Single	47	30	60	22	37
Married	49	27	68	22	34
Widowed	82	45	42	69	63
Divorced	72	67	–	80	79
All	50	29	59	26	38
Females					
Single	55	48	38	24	43
Married	58	33	53	16	35
Widowed	40	46	53	23	44
Divorced	71	–	–	17	41
All	55	37	50	18	38

*Episodes where diagnosis is other than those listed above have been excluded from this table.

TABLE X

Percentage of Episodes* associated with Mental Hospital Admission by Diagnosis and Social Class (Men Only). (Annual Average 1959 – 1962)

	Schizophrenia	Manic Depression	Senile Psychosis	Psycho neurosis Psychopathy	Total
Social Class†					
I	–	–	–	25	17
II	36	20	66	37	33
III	53	32	66	28	37
IV	60	24	14	16	29
V	65	35	69	33	43
	50	29	59	26	38

*Episodes where diagnosis is other than those listed above have been excluded from this table.

†Episodes where the social class was not known have been excluded, except in the total admission rate for each diagnosis.

GROUP PROBLEMS OF COMMUNITY CARE

M. W. SUSSER

Each of the facilities of the mental health service in the community provides a special milieu with a therapeutic aim. A number of problems are general to all these experiments. These are mainly concerned with group living, for instance problems of recruitment and exclusion, and of leadership. Each unit is concerned to form continuing groups while individual members pass more or less rapidly through them. Continuity is essential to building up and transmitting a workable system of norms of behaviour, and rules and sanctions to limit deviations from these norms. These definitions of behaviour must be appropriate to life in the community, and yet be consistent with the stability of formal relationships of authority within the institution. The two requirements are not readily compatible in every situation; it is particularly difficult to approximate the norms of hostel living with those of the home. Much hangs on the form or structure of the organisation, the character of the group, and the training and personality of staff.

The typical structure of large institutions for residential care cannot provide the whole range of roles common to the world outside, and therefore cannot socialise for community life, perhaps not even with radical reorganisation. Success cannot yet be claimed for hostels either, even though roles in the community are accessible to residents, but the work is only just beginning.

The character of a group is partly determined by the attributes of its

members, their age, sex, type of mental disorder, social class of origin and social ability. These attributes make up each patient's persona and delimit his status in the various situations of community care. They give a degree of predictability to behaviour in the recurring "encounters" of particular roles. Hence in weighing the chances of assimilating new recruits to a group, all these attributes must be weighed. They must be reckoned also in the obverse of assimilation, that is, exclusion and segregation.

Assimilation is effected through the congruence of the patient's image of himself with his image of the group to which he is recruited, and the reciprocal images of those who are already members of the group. For example, in an active club for mental patients in Salford assimilation failed when the admission of a number of young severely subnormal persons with physical stigmata retarded the further recruitment of older mentally ill patients. Similar difficulty was met in recruiting mentally ill patients to an industrial centre in which the majority were severely subnormal persons.

The images and perceptions which thus seem to hinder recruitment are shaped by the stereotypes of a culture but they are probably not fixed. Continuing interaction can dissolve the stereotype and replace it with the face behind the mask; long-established members of the club readily accepted subnormal patients as members. Submissiveness, as with some institutionalised and some subnormal patients, or withdrawal, as with some schizophrenic patients, may make the stereotype irrelevant. In the industrial centre, submissive patients with prolonged experience of institutions are not difficult to recruit, and withdrawn schizophrenic patients tend to resist contact with all groups and not only with the obviously subnormal.

Successful recruitment follows when the newcomer finds roles in the group which satisfy him and which are accepted by others. Within all larger groups cliques form which offer more or less satisfying roles on the basis of common interests and cultural affinities. There is much to learn about reducing the disruptive tendencies of cliques and realising their therapeutic and supportive potential for members. In a social club the mere provision of accommodation in which groups of varying composition and interest can disperse into diverse activity may obviate conflict and enhance both pleasure and personal support.

A group consists of a mesh of reciprocal roles. In 'milieu' therapy the roles a group affords its members are the basic instruments of learning. If the statuses and attributes of group members are homogeneous, the variation in roles and the types of exchanges are thereby limited. Homogeneous groups of patients can be expected to generate values characteristic of the single-sex groups found in such institutions as the armed forces and boarding schools. These are not the values of the community, and must tend to maintain the separateness of patients from the community. Heterogeneous groups of patients generate a greater variation in roles, learning situations and values, and reduce the pressure towards exclusiveness and segregation.

Heterogeneous groups make much greater demands on staff, however, who must learn to gain acceptance in the group for decisions which, by virtue of respecting the individuality of each member, inevitably discriminate between members. In the hostels, for instance, conflicts over discrimination can arise because the dependence of some patients is tolerated as inevitable and permanent, while at the same time other patients are pressed towards independence;

in the day centres, an effective system of incentives might well have to discriminate between subnormal and schizophrenic patients, as noted above. The comfortable tradition of uniform non-discriminating treatment within each group is carried over from traditional mental hospitals by both staff and patients, and has to be overcome. The threat of change within organisations gives rise to defensive anxiety, and this can conspire with the inertia of the established structure of relationships in an organisation to block change. We have discussed these difficulties elsewhere.

When patients come into conflict with authority, heterogeneity imposes solutions that discriminate between individuals. The nuclear family provides an analogy for socialisation in the heterogeneous group. Conflict is an essential accompaniment of the family process, and it is handled in an individual way by means appropriate to the status of the participants in the conflict. The integrity of the family group is maintained by the conditioned acceptance from birth of an asymetrical relationship of superordination and subordination between the old and the young generations, by the continual reinforcement of affective bonds,and by legal obligations. Cohesion of this order is not available to groups in institutions to protect their continuity; having to allow for idiosyncratic needs therefore promotes anxiety in staff about maintaining authority. "If you let one do it, then all want to do it."

The difficulty of making such individual decisions is added to because the groups are new and arbitarily constructed. The staff can draw neither on their own socialisation experiences and those of others, as parents do, nor can they appeal to the uniform rulings of the typical institution. At the outset the sanctions available in a hostel with voluntary patients are few, and their range is limited by the quality of domestic life which it affords. They are soon exhausted in those hostels which serve as little more than dormitories and the ultimate sanction of exclusion is quickly reached. Discipline is better accepted by group members when they themselves feel responsibility for it. Self-government through elected committees helps to foster a 'morality of co-operation' rather than a 'morality of constraint.'

Clearly the task of group supervision is difficult and demanding. There is no pool of trained staff to draw on. One solution is to attract staff from other fields with transferable training and another is to train them on the job. In order to do this psychiatrists and public health officers must study the methods and literature of social psychiatry.

PILOT STUDY FOR A LONG-TERM FOLLOW-UP OF PSYCHIATRIC PATIENT

FACTORS IN SOCIAL PERFORMANCE

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and

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Community mental health services can be seen as providing a variety of social situations and a range of social roles within which patients with mental disorder can be encouraged to assume normal social obligations. There is thus

an implicit assumption that alterations in social situations can influence the patient's social performance. The patient's intra-psychic state obviously influences his performance, and his intra-psychic state in turn may be influenced by his social situation and social performance.

It was our intention to test, in this follow-up study, the hypothesis that the patient's social performance would be influenced both by his social situation and by his clinical state. Late in the year we planned a small pilot study in order to test methods and definitions for such a study.

Participants in this study included the Salford Mental Illness Survey team with Drs. Adelstein, Stein and Susser of the Department of Social and Preventive Medicine, Manchester University, Dr. H. L. Freeman as psychiatrist, and all the mental welfare officers.

Sample.

The sample was selected by the following criteria:

(1) All Salford patients entering any psychiatric agency for special psychiatric care (mental health service, out-patient clinics, mental hospital) for the first time.

(2) Patients aged between 20 and 65.

(3) Patients presenting for the first time, in relation to the follow-up, exactly five years before; exactly four years before; exactly three years before; exactly two years before.

(4) Of patients presenting with the above criteria, all those with schizophrenia, every second case of psychotic depression, and all reactive depressions.

This amounted to 31 patients in all; 10 with schizophrenia, 19 with psychotic depression, 2 with reactive depression.

Method

Data was to be collected from the following sources:–

(1) Interviews carried out by trained social workers (mental welfare officers of the Salford mental health service).

(2) Interviews with a psychiatrist in half the cases.

(3) Agency records.

Social Worker Interviews

Whenever possible, both a relative (or person closest to the patient) and the patient were interviewed independently. In the main the interviews were semi-structured; the information was collected systematically but not by means of prescribed wording.

In addition to the semi-structured interviews, symptom inventories were

used both for patients and relatives. On the whole these inventories were very similar to those designed by Katz et al. The interviews covered three aspects of social roles :–

(1) Social Performance
- Work
- Household
- Leisure activities

(2) Social situations
- Composition of domestic unit
- Kin networks
- Migration
- Cultural origins
- Education
- Socio-economic position
- Work situation
  - (a) Type and duration of employment
  - (b) size of working group
  - (c) dependance of fellow-workers on patient
  - (d) dependance of management on patient

(3) Intra-psychic clinical state :
- Patient's symptom inventory
- Relative's symptom inventory
- Social worker's assessment
- Psychiatrist's interview

Problems in Method

(1) Only 19 of the 31 interviews were completed.

2 patients had died, during the follow-up period.

7 patients were not traced in a first-stage search. We would expect to find most of these patients on prolonged search.

3 patients refused interviews. This is a high rate of refusal, and was perhaps related to our using mental welfare officers rather than social workers appointed specifically for research. The officer in a service is client-orientated, and hesitates to press for information or to jeopardise possible future relationships.

(2) Difficulties with inventories.

(i) 2 patients had no other person who could fill in the relative's inventory.

(ii) The social workers found it difficult to hand over inventories to be completed by patients and relatives, and they tended to ask the questions and complete the forms themselves. This made the interviews longer than intended.

(iii) The reliability of any one inventory alone is questionable. In some cases the relative's inventory was less informative than the patient's

inventory, whereas in others the reverse obtained. The observations of the mental welfare officers, all of whom had experience with psychiatric patients, were a useful check on the symptom inventories.

(iv) No adequate validation of these two inventories against psychiatric interviews has yet been carried out. The inventories were assessed by our clinical judgements applied to the available answers. There were only six psychiatric interviews in all

(3) Acceptance of Psychiatric Interviews.

6 patients accepted interviews.

2 patients refused interviews.

In 3 cases the social worker did not feel he had reached the degree of rapport necessary to invite the patients to come to a psychiatric interview.

8 patients were not invited to attend.

Conclusions on method

(1) The experience and training of mental welfare officers was valuable in making assessments and observations, and as a group they were able to help in developing hypotheses. Mental welfare officers were handicapped in research interviews by their service obligations. This led to a high rate of refusals of both social and psychiatric interviews. For systematic surveys it would probably be better to employ trained psychiatric interviewers with the experience of mental welfare officers, but especially detailed for research work.

(2) Although interviewers expressed doubts about the use of inventories, they may yet prove useful instruments if they can be validated and revised in such a way that the research workers find them easy to hand over to subjects for completion. This may require a design on a different principle, in which all questions are not obligatory.

Results

Definitions and criteria used in the analysis cannot be given in detail here. The analysis has related the patient's social performance to his clinical state and social situation.

Performance in work, in domestic, and in leisure roles was separately scored; each scale ranged from unimpaired performance to total incapacity. The scores were then combined to give four categories of social performance.

Assessments of these roles have been made in terms of conventional social norms for the cultures to which the patients belong. The result of the combined scores was as follows:

Unimpaired function	:	10
Moderate impairment	:	2
Severe impairment	:	5
Total incapacity	:	2

We have described the patient's adjustment in home and neighbourhood as *accommodation* (after Simpson, Messenger: and Towne, 1962). By accommodation we mean the degree to which the roles which the patient actually performs in the household, and the expectations and demands which others in the household make on him, are reciprocal and adjusted to each other. This has been judged by friction and hostility between family members and others. Accommodation has also been graded on a four-point scale from satisfactory (patient's role accepted in the household) to no accommodation possible (members of the domestic unit unable to maintain continuous relations with each other).

The results were as follows:

Satisfactory	:	10
Some resentment	:	5
Marked hostility	:	2
No accommodation possible	:	2

Intra-Psychic Clinical State was also graded on a four-point scale:—

No symptoms	:	5
Mild symptoms	:	8
Moderate symptoms	:	3
Marked symptoms (obvious in most aspects of observed behaviour)	:	3

Table II sets out all the results for each patient.

Conclusions

Social performance and accommodation show an extremely high relationship (see Table I). Nine of the 10 patients with unimpaired performance had satisfactory accommodation. One patient had satisfactory accommodation but poor social performance in conventional roles. This patient had a role in the household which was useful and acceptable to other members. This supports the results of Brown, Monk, Carstairs and Wing (1962) on the importance of family adjustment to performance.

Social performance was closely related to clinical intra-psychic state, but less so than to accommodation (see Table I). All but one with unimpaired social performance either had no symptoms of psychiatric disorder (4 patients) or mild or moderate symptoms of psychiatric disorder which were not obvious in observed behaviour (5 patients).

The exception with good performance and marked symptoms was a woman of retiring age who had a 20 year history of delusions, and of successful accommodation to these on the part of the husband.

PILOT FOLLOW-UP

TABLE I

Social Performance by 'Accommodation', Intra-Psychic State, and Admission

	Accommodation Score				Intra-Psychic State Score				Inception with Hospital Admission	
Social Performance Score	1	2	3	4	1	2	3	4	No	Yes
1	9	1	–	–	4	5	1	–	7	3
2	–	2	–	–	1	1	–	–	1	1
3	1	1	2	1	–	2	1	2	3	2
4	–	1	–	1	–	–	1	1	–	2
Total	10	5	2	2	5	8	3	3	11	8

In this very small sample negative results must be treated with caution. The influence of factors obtaining at the time of the patient's entry into psychiatric care, and of social factors generally, could not be expected to emerge. The outcome for depressives and schizophrenics was much the same, and the period of follow-up made no difference. The type of domestic unit and the strength of the supportive kin network did not emerge as factors. But it seems probable from the data that the prognosis of patients who were admitted to mental hospitals at the inception of their illness was worse than that of those who were not, irrespective of diagnosis. Seven of eleven patients who were not admitted and three of eight who were admitted had unimpaired social performance; none who were not admitted, and two who were admitted, were totally incapacitated.

Interpretation of this result is complicated. Illnesses dealt with in out-patient units may be less progressive than those dealt with in mental hospital, even though the diagnosis is the same; or they may be milder illnesses, so that the mental hospital selects only severe deteriorated psychosis for admission; or they may be at an earlier stage in out-patient units, and progress might be delayed by early treatment; or progress might be affected by differences in the treatment given, or more likely, by the different reputation which a patient acquires, among relatives and professional colleagues, from out-patient units and from mental hospitals.

This pilot study suggests that a sample drawn from all patients who have come into contact with psychiatric agencies, and not only from those who were admitted to hospital, can cast fresh light on prognosis and its relation to social and clinical factors. Moreover it suggests that accommodation in the home is clearly related to the social performance of psychiatric patients.

PILOT FOLLOW-UP – INDIVIDUAL CASE DATA
TABLE II

Diagnosis	Age	Sex	Year of 1st agency contact	1st agency contact	Intra-Psychic State	Social Per-formance	Accommo-dation	% follow up time incapaci-tated	Living with
Schizophrenia	38	M	1960	M.H.S.	1	1	1	5%	Single with father
Manic Depressive	36	M	1961	O.P.	1	1	1	–	Single alone
Schizophrenia	20	M	1962	M.H.S. & O.P.	2	3	3	95%	Married with a step-child
Reactive Depressive	43	M	1962	O.P.	4	3	2	12½%	Wife and dep. child
Manic Depressive	29	M	1961	Ment. Hosp. & O.P.	1	2	2	16%	Wife and dep. child
Manic Depressive	66	M	1962	O.P.	2	1	1	0 (retired)	Wife
Manic Depressive	56	F	1959	Ment. Hosp.	2	1	1	0 to 5%	Widow & indep. child
Schizophrenia	36	F	1959	M.H.S. & Ment. Hosp.	1	1	1	5%	Husband
Schizophrenia	25	F	1960	Ment. Hosp. & M.H.S.	2	3	4	25%	Husband, parents-in-law, children
Manic Depressive	43	F	1960	Ment. Hosp. & M.H.S.	3	4	2	100%	Husband

TABLE II (continued)

Diagnosis	Age	Sex	Year of 1st agency contact	1st agency contact	Intra-Psychic State	Social Performance	Accommodation	% follow up time incapacitated	Living with
Manic Depressive	34	F	1962	M.H.S.	1	1	1	–	Husband & dep. child
Reactive Depressive	68	F	1962	O.P.	2	1	2	–	Single alone
Schizophrenia	60+	F	1962	M.H.S.	3	3	3	95%	Divorced alone
Manic Depressive	25	F	1959	M.H.S. & O.P.	2	1	1	–	Husband & dep. child
Manic Depressive	41	F	1960	M.H.S. & Ment. Hosp.	4	3	1	100%	Single, 2 sisters
Manic Depressive	± 50	F	1962	M.H.S. & Ment. Hosp.	4	4	4	12½%	Widow & dep. son
Schizophrenia	± 60	F	1960	M.H.S. & Ment. Hosp.	3	1	1	2%	Husband
Manic Depressive	54	F	1962	O.P.	2	2	2	physically incapacitated	Divorced, co-habiting
Manic Depressive	39	F	1959	O.P.	2	1	1	5%	Husband & dep. child

M.H.S. Mental Health Service
Ment. Hosp. Mental Hospital
O.P. Psychiatric Out-Patient Clinic
dep. dependent

THE PSYCHIATRIST IN A COMMUNITY MENTAL HEALTH SERVICE

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"Community care" is a phrase which has come into frequent use in recent years, but which has been interpreted in very different ways. In North America, it usually appears to mean the provision of extra facilities for psychotherapy at out-patient clinics, under special financial arrangements. In this country, "community care" is often used loosely, to refer to all facilities which are responsible for patients outside hospital. But as Dr. Duncan MacMillan has pointed out, the true meaning of a "Community Mental Health Service" is a comprehensive service of care and treatment for a defined population, including full hospital facilities. An essential feature of such a service is that the hospital accommodation – whether in a mental hospital, or a general hospital psychiatric unit, or both, be acceptable to the population served. It must therefore be of a type which is appropriate to present day needs. In many respects, the current medical and social situation in this country is one particularly well suited to the development of this type of service.

If we accept that a community service should attempt to meet the total needs of its population in respect of psychiatric illness, it cannot be a service based on individual psychotherapy as the primary mode of treatment. Psychotherapy, both individual and group, should be one of the treatment facilities available in a comprehensive service, but treatment in most cases must be mainly on pharmacological, physical or environmental lines, if the community as a whole is to be served. An attempt can then be made to deal with the total problem of overt psychiatric illness, together with such social and forensic problems as are considered to require psychiatric intervention.

Within defined areas, a true community service must have continuous and final responsibility, whatever the clinical state of individual patients. It must therefore be non-selective and non-rejecting in its operation, though the degree to which different categories of patients can be helped will obviously vary widely. To achieve this, there must be a limitation of therapuetic goals, with stress on maintaining realistic levels of function rather than attempting to mould personalities.

Community services in this country are applicable to the whole range of psychiatric disorders, and thus reflect the comprehensive nature of the National Health Service. Their form, however, is governed by the division of the N.H.S. into three sections – hospitals, public health services and family doctors – each of which is organised through a separate authority. All three sections must be equally involved in a comprehensive community mental health service, and this administrative division is a continuous challenge, which demands co-ordinated action and shared responsibility.

It is fundamental that patients should not be forced into rigid compartments of responsibility, which are the exclusive concern of individual services, and under the mental health Act, local health authorities now have complete freedom to use the facilities of various departments for the needs of the mentally ill. Only an integrated service has a wide enough range of facilities to be able to treat the patient appropriately at every stage of his illness. It

must also maintain outside links with many social, education and rehabilitation services and should be able to offer sheltered accommodation and employment to the handicapped over prolonged periods. Flexibility is essential for a service which deals with the whole range of psychiatric illness and with the problems of mental subnormality, as well as serving all social classes.

The National Health Service is "comprehensive" both in the sense of supplying all forms of medical treatment and care, and in its coverage of the whole population. The fact that these services are now used by almost all social groups has been an important influence in raising the standards of the services themselves since 1948. A community mental health service is also "comprehensive" in the same two senses. It must offer a continuous spectrum of services, from full time, permanent care in an institution on the one hand, to occasional support for a patient in the community on the other. It must also serve the total community. It should therefore, include every type of facility, and offer every form of treatment which is appropriate to mental illness and subnormality. The quantity of these services which will be available, and the standard at which they are supplied, will of course depend on how much of its resources the community is prepared to allocate to mental health, at both, regional and national levels. There is also the question of assessing priorities within the service itself. If this is to be done primarily on the basis of human needs, then there will be first call on the available resources for the three problems of schizophrenia, subnormality and senility. In all these cases, there is a particular need to avoid the "all or nothing" principle of offering institutional care to the severely disturbed, and no help to anyone else. Up to now, the development of our mental health services has been notably more successful in the direction of diagnosis and assessment, than in that of providing treatment for patients who require much individual attention. But only a substantial increase in the absolute amount of finance for these services can allow this problem to be solved.

At times, there may be little difference between the medical and nursing needs of some patients in hospital and others living with their families, though it is extremely difficult to provide anything like the same degree of support in the community outside. Care in the family of those with chronic handicaps or personality problems is bound to cause distress to relatives, not only through crises of acute disturbance, but in details of everyday behaviour. It is therefore the duty of those who work mainly in hospitals to have such family burdens constantly in mind, and to treat admission and discharge as not merely medical but also as social procedures. In the community mental health service in this area, the most urgent requirements are sheltered accommodation and employment on a large scale, which need to be related to a programme of industrial therapy within the hospitals. It is likely that many of the existing mental hospital functions could be replaced by a complex of hostels and sheltered workshops, whereas the acute treatment units could be integrated with the general hospitals. These facilities, linked to the community services of the local health authority should offer a worthwhile and truly comprehensive psychiatric service.

TEACHING THE MENTALLY HANDICAPPED

A. CASHDAN AND E. A. LUNZER

(Manchester University Department of Education
and
Educational Advisers to the Salford Mental Health Service)

It has been the policy of the Authority over the last two or three years to encourage the development of a freer atmosphere in all of our Centres. In both Junior Centres, at Wilmur Avenue, and at Seedley, it is felt that the children stand to gain a great deal from a regime in which they are at liberty to choose their own occupation from a wide range of stimulating and readily accessible material, and to carry on with such activity, either individually or in groups, with support, suggestion and encouragement from supervisory staff, but with the minimum of let and interference. In particular, it is thought that the opportunities for social interchange between children in various forms of play, including especially dramatic "pretend" play and the exercise of physical skills, will be conducive to their social and intellectual development. Children learn the benefits of co-operation most readily in a situation where they are free to find their own disputes, and to settle them on their own so far as possible. Naturally supervisory staff have the responsibility of ensuring that no one is bullied or ostracised over a period. There is also reason to believe that the intellectual development of subnormal children, like that of normal, is greatly assisted by the maximum opportunity for the use of language as a means of social exchange, and for influencing their own behaviour and that of others. Children engaged in different activities will talk about what they are doing, both to themselves and to others, and this helps them to gain a greater insight into what they are doing, as well as fostering the use of language in the solution of their problems.

These policies have increasingly permeated the work of our junior centres, and in consequence they are happier places, both for children and for staff. It should be added that there is little ground for certainty in the detailed decisions as to which measures will prove satisfactory, and which will fail (e.g. in choosing materials, in decreasing restrictions on movement anywhere in the centre, in substituting personal responsibility for group routines in such things as personal hygiene, etc.) Mistakes have been made and will continue to be made. But they are a small price to pay for the advantages to be gained from experiment.

Both in junior and in senior training centres increases in staff should enable us to make a beginning in regard to a number of much-needed developments. In the Seedley Centre, the recruitment of a sorely needed additional assistant supervisor will enable us to increase our allocation of supervisory time to the older and more able children, and to develop various useful activities including rather more ambitious and realistic training in handicrafts as a preparation for transfer to senior centres, and to increase the systematic teaching of reading and number. A more adequate staffing ratio is an essential precondition for an increase in the number of outside activities undertaken by our centres, including visits to places of interest, walks, etc. The importance of these can hardly be exaggerated, in view of the general tendency for the mentally handicapped person to be particularly deficient in the range of his social know-how. Because of limited social horizons, his independence is

seriously curtailed. A widening of these horizons should lead to a greater independence and therefore constitutes a valuable social training. Nor should it be forgotten that because of his handicap, the frequency and intensity of such experience needs to be greater than for the normal child who can pick up a lot in the course of his extra-educational activities and who is in any case less sheltered than the handicapped child.

Part-time teaching of reading in the evening after centre hours has continued to be a feature of our work and up to 25 patients, mainly young adults from the Crescent and Broad Street Centres, have taken part in these. Results so far are encouraging, though not always spectacular. It is hoped to have in addition the services of a day-time teacher, not only for help in reading and number work for adolescents and younger adults, but also in order to help in their social training. Thus the proposed institution of domestic science training as a regular feature of our work at the Crescent Training Centre constitutes a step in the right direction.

Throughout the adult training centres, the problem of securing a greater feeling of worthwhileness, based on the provision of adequate incentives, and on methodical work designed to help patients to realise the meaning of such incentives (e.g. the value of money, the appreciation of standards of output in respect of quality and of quantity) remains one of our most urgent tasks. Nevertheless, the simulation of an industrial atmosphere is not our only aim, and adult as much as junior centres must continue to provide much needed social training as well as opportunities for creative and recreative experiences. These problems are not likely to be solved easily; and here again, it is felt that progress will be secured more readily, given a preparedness to experiment, and even where necessary to make mistakes.

Research

Recent years have seen a marked renewal of interest in problems of mental handicap, among qualified psychologists, and in particular in the study of the specific assets and difficulties of handicapped children and adults. Workers in the field of subnormality are well acquainted with the thorough and painstaking laboratory investigations of N. O'Connor and B. Hermelin. Inspired by some of their early findings, A. D. B. Clarke was able to show that given the right kind of training and motivation, adult patients were able to achieve a degree of skill and speed in the execution of simple industrial tasks which was in every way comparable to that of the non-handicapped. N.O'Connor and H. C. Gunzburg, have, among others, been associated with advances in teaching the mentally handicapped to read. M. Woodward has recently shown that it is not unusual for older mentally handicapped children and adult patients to show an important beginning of number sense.

Both in this country and abroad, many have been concerned to establish not only what were the learning potentialities of the mentally handicapped, but also to discover in what areas they were most deficient, and why. Nearly all investigators agree that language presents a special difficulty, and in the Soviet Union, Professor I. R. Luria has suggested that the most significant feature of handicap is a constitutional inability to use language for the direction or control of behaviour. However, in the course of the well-known Brooklands experiment, Drs. Lyle and Tizard have been able to show that some of the language deficit may be overcome by the provision of a freer and

more socially stimulating environment. Thus we do not know how far the difficulties found by Luria are irreversible, nor can we be sure how far they are general. In America Professors D. J. House and B. Zeaman have pointed to specific difficulties experienced in the area of simple perceptual discrimination. Again we are not sure of the reasons for such failure.

It is wholly possible that some of these difficulties are due to failures of motivation. Thus it may be that when the task is too simple or too artificial, the handicapped fail to appreciate it as a task. Similarly when it is too complex or too closely embedded in the largely familiar but imperfectly understood, they fail to isolate what is new and to be learnt.

In the course of a recent investigation undertaken by Mrs I. Hulme*, we were surprised and pleased to find that given the opportunity to select and organise their own play environment, handicapped children showed a spontaneity and constructiveness which was on a par with that of normal children at the same level of all-round average mental development (younger children matched with the handicapped for mental age). But we too found that language was poor in comparison with the younger normal child. We also found considerable difficulty in a test where the child was required to reproduce various arrangements of coloured building bricks. We are not sure what relation if any there might be between this last task and language behaviour. One possibility is that handicapped children do not readily learn and use any kind of 'shorthand code' to isolate and store the elements of their experience, Language is such a code, and a more or less well-organised imagery would be another. But once again it may be that the failure is principally one of motivation. Or it may be that handicapped children are simply 'slower learning,' even than children of the same mental ages, no matter what the thing to be learnt, and that the test happens to set a task involving learning (because the arrangements may be unfamiliar or arbitrary).

In the course of the next two years, we hope to look into some of these questions further. In particular, we want to find out whether there is this difficulty in all learning, how much learning is involved in the sort of problems we were using, and whether it is indeed true that the use of language cannot help the handicapped so much as the normal. This work will be financed by a grant to Dr. Lunzer from the Salford Society for Mentally Handicapped Children. Mrs. Hulme will continue to assist in the research.

STAFF AND FACILITIES

Our work is still handicapped by an insufficiency of transport which results in long periods of travel and the consequent shortening of the effective training period. In the coming year, we shall receive our own ambulance, and this will certainly help, although the problem will not thereby be solved.

Existing centre buildings are far from satisfactory, and the progress reported needs to be measured in the light of this. There is little doubt that a great impetus to our work will accrue when we are in a position to move to the new buildings. Progress in this matter has been extremely slow.

*Mrs. Hulme, remedial teacher to the Salford Mental Health Service, carried out this work with the help of a fellowship from the Susan Isaacs Memorial fund under the direction of Dr. E. A. Lunzer.

We were sorry to lose late last year the services of Miss Lord as Supervisor at the Seedley Centre, but we have been fortunate in securing Mrs. Glover to take over this Centre, and the atmosphere there continues to be happy and purposeful. We have also been able to appoint an additional assistant supervisor in the Wilmur Avenue Centre, and a similar appointment will soon follow at the Seedley Centre.

During the autumn months of 1963, a group of 8 experienced teachers of handicapped children, enrolled in a course at Manchester University under the direction of Mr. Cashdan, were able to devote one session per week to work in our centres. The experience proved valuable to the students, but was not less valuable to the centres in which they worked, for these enjoyed the the benefit of exchanging ideas and seeing the potentialities of branching out into new lines of activity. It is hoped to continue the arrangement in the coming session.

In addition two students from the Mental Health course under the direction of Mrs. Mildred Stevens were placed for practical work in our training centres.

THE PAEDIATRICIAN AND THE PROBLEM OF SUBNORMALITY

R. I. MACKAY, *Consultant Paediatrician*
to Salford Health Department and Hope Hospital

The work of the paediatrician has changed during recent decades, so that his problems are different from those he was trained to handle. A generation ago he was mainly concerned with acute infectious illness and its devastating consequence. Children became ill suddenly and died suddenly. Preventive measures were based chiefly on techniques of hygiene, immunisation and education about feeding. As infection became manageable and the death rate among children fell to minute proportions, other problems began to arise, although in small numbers compared with the former toll. Patients who had survived major infections and recovered imperfectly grew up with a variety of handicaps, some of which interfered with the functions of the brain. Among other children in whom infections were successfully treated or prevented, fresh problems emerged in relation to the developing brain. Often co-ordination of limb movement and body control are affected together with the brain and sense organs. Such a child exhibits slow or distorted development both in physical growth and behaviour; blind, deaf, and spastic children and those with mental subnormality can all be included in this group. Some patients have more than one of these handicaps.

It is a sign of these changes that the paediatrician is becoming closely involved in the work of the community mental health service with mentally subnormal children. Accurate medical diagnosis is now a matter for the first weeks or months of life, and treatment and education can be planned from these early days. Much of this falls to the lot of any paediatrician in the course of hospital work, but in Salford we have been able to develop a co-ordinated service for the mentally subnormal in which the boundaries between hospital paediatrics and community care through the local health authority have virtually ceased to exist. The great majority of referrals of mentally subnormal children to the Salford mental health department are now made in the first

five years of life; and the sources of referral at these ages include both the general hospital and the maternity and child welfare services. (see appendix VIA) There is, in fact, continuous care from the new-born period to adulthood; continuing consultation takes place between staff in all branches of the service. As a result the mentally subnormal child is reaping the benefits of the modern advances in knowledge more abundantly in Salford than in some other areas.

In addition to the monthly clinic at which children and parents are seen by the paediatrician and a medical officer of the mental health department, the paediatrician regularly visits the junior training centres to examine children and consult with staff. These assessments serve both to improve our management of each child and to enlarge our understanding of the general problem. But we cannot advance far without research and experiment, and this has not been neglected. Apart from epidemiological studies and systematic investigation of cases, we have recently conducted trials of treatment which in this field is a complex undertaking. (J. Ment. Def. Res., 1963, page 107).

A system for the study of the child of slow development, the study of hysteropaedics (Greek hustero = to be found wanting, and paes = a boy), has been emerging quietly as certain paediatricians have found more and more of their time taken up by this kind of case. Although the numbers are small, the problems are complex and ill-understood.

Much time has to be spent by the physician and by ancillary workers, each contributing from their own professional standpoint, to the understanding of the handicapped patients. Children with certain kinds of handicap have stimulated more interest than others, and we are now familiar with services and societies for the cerebral palsied child, the deaf child, and the blind child. Interest has been much less ready when handicaps have been multiple, and particularly when the child has seemed to be unsuitable for education. As a result of the limited medical and psychological advances of the last few years, however, a new enthusiasm has arisen. Some medical schools have made this work a major feature of their work and teaching, and in certain places this study is being taken up with an intensity and concentration which justifies a new speciality.

The physician's function in this exercise involves both child and parents. Complex clinical problems arise among children with multiple physical and mental handicaps. Clinical skill of the highest degree has to be integrated with an appreciation of the total situation in order to minimise crippling handicaps and to allow the child's personality to blossom. This involves not only well understood medical treatment, but also the more difficult task of advising parents and ancillary workers. Not the least of the problems is helping parents to achieve an adjustment to this most terrible disappointment so that they are in a position to help and encourage their child in its development.

Enough is known about some of the causes of subnormality to prevent, through treatment, damage to the child's development. Such disorders need to be discovered and treated very early in life. Unfortunately, they represent only a minority of cases and many others await solution. Methods are needed which will make it possible to discover causes of physical and mental handicap in the newborn, if possible before irreversible damage occurs. This

is already being done in small measure, but the pace of the work must be stepped up. We must assume that no newborn infant is normal until proved so by examination and tests. The natural tendency to regard the newborn infant as making a clean start in life is fallacious. Indeed the timetable of observation needs to be pushed back into pregnancy; screening and medical care should apply to the unborn child. Many causes of mental and physical handicap take effect early in pregnancy. We can hope to achieve their control, difficult as this may be, for existing knowledge already points the way.

The future holds exciting developments in the field of mental subnormality. It should be possible to transform the present situation by treating many more types of subnormality and by enabling mentally handicapped persons to lead more useful and profitable lives among friends and neighbours. The most important advances, however, must surely take place outside the recognised field of mental subnormality in the care given during gestation, confinement, and the newborn period.

All that has been said refers to the problems of professional workers and parents. A duty also lies with those who have no such intimate contact with the mentally subnormal. It is as important that normal people should be aware of and sympathetic to the problems of the mentally subnormal as to those of spastics and sufferers from poliomyelitis and cancer. Mental subnormality is no different from these conditions, and our community must aim for the same level of understanding.

APPENDIX I

MENTAL ILLNESS

Sources of Referral to Salford Mental Health Service (Percentage of Total Notifications)

Agency	Males	Females	TOTAL				
	1963	1963	1959	1960	1961	1962	1963
General Practice	49	57	45	52	51	53	54
Health/Welfare/Voluntary Organisation	4	6	11	6	8	3	5
Police/N.S.P.C.C.	6	2	4	6	5	3	4
Hospital Psychiatrist	11	14	9	10	12	16	12
General Hospital	5	3	5	5	6	3	4
Relatives	16	10	15	11	11	16	13
Other	9	8	11	11	8	5	8
	100	100	100	100	100	100	100
Total Number	239	354	503	587	555	589	593

APPENDIX IIA

All Notifications of Female Patients Referred for Mental Illness to Salford Mental Health Service in 1963
By Source of Referral and Disposal (Percentages)

Disposal	SOURCE OF REFERRAL								
	G.P.	Health/ Welfare/ Voluntary Organisation	Police/ N.S.P.C.C.	Hospital Psychiatrist	General Hospital	Relatives	Other	Total Number	Total %
Compulsory Admission	18	5	38	10	10	37	24	66	19
Voluntary Admission	31	24	26	10	20	9	10	82	23
Psychiatric O.P. or Domiciliary Visit	17	5	12	19	10	11	7	53	15
Home Support (and G.P.)	20	19	12	42	30	29	28	87	24
Other	14	47	12	19	30	14	31	66	19
Total Percentage	100	100	100	100	100	100	100	–	
Total Number	203	21	8	48	10	35	29	354	
Percentage of Total Referrals of Female Patients	57	6	2	14	3	10	8	–	100

APPENDIX IIB

All Notifications of Male Patients Referred for Mental Illness to Salford Mental Health Service in 1963

By Source of Referral and Disposal (Percentages)

Disposal	SOURCE OF REFERRAL								
	G.P.	Health/ Welfare/ Voluntary Organisation	Police/ N.S.P.C.C.	Hospital Psychiatrist	General Hospital	Relatives	Other	Total Number	Total %
Compulsory Admission	30	20	36	8	38	26	10	62	26
Voluntary Admission	26	20	21	16	23	15	15	52	22
Psychiatric O.P. or Domiciliary Visit	12	–	7	12	8	3	–	20	8
Home Support (and G.P.)	24	40	14	40	23	41	55	74	31
Other	8	20	22	24	8	15	20	31	13
Total Percentage	100	100	100	100	100	100	100	–	
Total Number	118	10	14	25	13	39	20	239	
Percentage of Total Referrals of Male Patients	49	4	6	11	6	16	8	–	100

APPENDIX III

Disposal of All Patients Referred to Mental Health Service 1959 – 1963*

Agency	1959	1960	1961	1962	1963
Compulsory Admission	98 } 52%	114 } 48%	94 } 45%	53 } 35%	105 } 41%
Voluntary Admission	126 }	123 }	119 }	111 }	101 }
Out Patient, Domiciliary	46 }	29 }	53 }	86 }	61 }
Home and G.P.	110 } 48%	146 } 52%	144 } 55%	157 } 65%	157 } 59%
Other	50 }	86 }	60 }	60 }	84 }
TOTAL	430	498	470	467	508

* Disposal at first notification in calendar year.

APPENDIX IV

Use of Psychiatric Agencies: Episodes in Salford – 1961, 1962 and 1963

	1961	1962	1963
Mental Hospital Admissions via Mental Health Service			
Compulsory	124	77	128
Voluntary	128	155	134
Direct	66	67	45
General Hospital Admissions	11	20	50
Total Admissions	329	319	357
Out Patients	285	339	312
Mental Health Service only	212	271	271
GRAND TOTAL	826	929	940

APPENDIX VA

The Case-Load in Mental Illness*

	1959	1960	1961	1962	1963
A. Number of new patients referred	233	239	255	260	298
Number of known patients referred	197	259	215	207	210
Total patients referred	430	498	470	467	508
Second and subsequent referrals during calendar year	73	89	85	122	85
Total referrals	503	587	555	589	593
B. Total number of visits‡	5,297	4,692	4,533	5,558	7,137
Number of officers (units time per annum)	6	5.6	† 5.06	† 6.63	† 9.03
Average number of visits per officer	883	840	896	838	790
Index of visits per officer	100	95	101	95	89
C. Average number of new patients referred per officer	39	43	50	39	33
Average number of known patients referred per officer	33	46	42	31	23
Average number of referrals per officer	84	105	110	89	66
D. Average number of visits per patient referred	12.3	9.4	9.6	11.9	13.8
Average number of visits per referral	10.5	8.0	8.2	9.4	12.0
Index of visits per referral	100	76	78	90	114

* Excludes cases resident outside Salford (19 in 1963)
‡ Includes office interviews, visits to hospitals, etc.
† Excludes trainees, and Senior Officer who since 1961 has not undertaken casework.

APPENDIX VB

The Case-Load in Mental Subnormality

	1959	1960	1961	1962	1963
Number of cases on register	669	681	687	665	672
Total number of visits	3,263	2,735	2,219	2,291	2,855
Number of officers	6	5.6	5.06	6.63	9.03
Average number of visits per officer	544	488	439	346	316
Average number of cases per officer	111	122	136	100	74
Average number of visits per case	4.9	4.0	3.2	3.5	4.3

APPENDIX VI

New Notifications of Mentally Subnormal Persons, 1963. By Sex, Grade and Age

GRADE*	MALES									FEMALES									Total Males and Females
	AGE								Total	AGE								Total	
	0 – 4	5 – 9	10 – 14	15 – 19	20 – 29	30 – 39	40 – 49	50 +		0 – 4	5 – 9	10 – 14	15 – 19	20 – 29	30 – 39	40 – 49	50 +		
Low	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Medium	–	–	–	1	–	–	–	–	1	1	–	–	–	1	1	–	–	3	4
High	–	–	–	1	–	1	–	–	2	3	–	1	1	1	1	–	1	8	10
Undetermined	12	–	–	–	–	–	–	–	12	5	–	–	–	–	–	–	–	5	17
TOTALS	12	–	–	2	–	1	–	–	15	9	–	1	1	2	2	–	1	16	31

*Low = I.Q. < 30. Medium = I.Q. 30 – 50. High = I.Q. > 50.

APPENDIX VIA

New Notifications of Mentally Subnormal Persons, 1963. By Age, and Source of Referral

Source of Referral	AGE								Total
	0 – 4	5 – 9	10 – 14	15 – 19	20 – 29	30 – 39	40 – 49	50 +	
Maternity and Child Welfare	16	–	–	–	–	–	–	–	16
Director of Education	–	–	1	1	–	–	–	–	2
General Hospital	4	–	–	–	1	–	–	–	5
Immigration	–	–	–	–	1	2	–	1	4
Others	1	–	–	2	–	1	–	–	4
TOTAL	21	–	1	3	2	3	–	1	31

APPENDIX VIB

New Notifications of All Mentally Subnormal Persons 1959 – 1963

Age Groups:– 0 – 4 years and 15 – 19 years

Age	0 – 4 years		15 – 19 years		Total Notifications at all ages
Year	Number	Percentage of total Notifications	Number	Percentage of total Notifications	
1959	13	32%	12	29%	41
1960	7	18%	19	50%	38
1961	11	42%	3	12%	26
1962	17	59%	4	14%	29
1963	21	68%	3	10%	31

APPENDIX VIC

New Notifications during 1963 of Mentally Subnormal Persons

Under Five years of age

0—	1—	2—	3—	4—	0–5
1	1	9	8	2	21

APPENDIX VII

Alterations in Status of Mentally Subnormal Persons on the Salford Register during 1963 by Age and Sex

	MALES									FEMALES									Total Males and Females
	AGE								Total	AGE								Total	
	0 – 4	5 – 9	10 – 14	15 – 19	20 – 29	30 – 39	40 – 49	50 +		0 – 4	5 – 9	10 – 14	15 – 19	20 – 29	30 – 39	40 – 49	50 +		
Discharged from care	–	–	–	–	2	–	–	–	2	–	–	–	2	1	–	1	–	4	6
Migration	–	–	–	–	2	1	1	–	4	1	1	–	–	1	1	–	–	4	8
Death	1	1	1	–	1	2	1	1	8	–	1	–	–	1	–	–	–	2	10
Discharge from Institutions	–	–	–	–	–	–	–	–	–	–	–	–	–	1	2	2	1	6	6
Admitted to Institutions (Long-Term)	–	–	2	3	3	1	1	1	11	–	1	1	2	1	2	1	–	8	19
Temporarily admitted to Institutions	–	1	2	–	–	–	–	1	4	–	1	1	1	–	2	–	–	5	9
Waiting List for Institutions	–	–	–	–	–	–	–	1	1	–	–	1	1	–	–	–	–	2	3
From Hospital to Leave of Absence	–	–	–	–	–	–	–	2	2	–	–	–	–	1	–	1	–	2	4
From Leave of Absence to Hospital	–	–	–	1	–	–	–	–	1	–	–	–	–	–	–	–	–	–	1

APPENDIX VIII

Long-Term Admission of Subnormal Persons from Salford 1948 – 1963 (inclusive)

by Year, Grade and Age at Admission

Year	Grade*	AGE									Total Severely Subn.
		0 – 4	5 – 9	10 – 14	15 – 19	20 – 29	30 – 39	40 – 49	50 +	Total	
1948-59	High	–	–	3	19	5	–	1	2	30	47
	Medium	–	1	2	7	8	8	6	1	33	
	Low	1	3	7	1	1	–	1	–	14	
	Total	1	4	12	27	14	8	8	3	77	
1960	High	–	–	–	3	–	–	–	–	3	7
	Medium	–	–	1	1	1	1	–	–	4	
	Low	–	1	2	–	–	–	–	–	3	
	Total	–	1	3	4	1	1	–	–	10	
1961	High	–	–	1	–	–	–	–	–	1	4
	Medium	–	–	–	–	–	1	–	1	2	
	Low	1	–	1	–	–	–	–	–	2	
	Total	1	–	2	–	–	1	–	1	5	
1962	High	–	–	–	2	2	–	–	–	4	2
	Medium	–	–	–	2	–	–	–	–	2	
	Low	–	–	–	–	–	–	–	–	–	
	Total	–	–	–	4	2	–	–	–	6	
1963	High	–	–	–	1	3	–	–	–	4	15
	Medium	–	–	1	4	1	4	2	1	13	
	Low	–	1	1	–	–	–	–	–	2	
	Total	–	1	2	5	4	4	2	1	19	
1948-63 Total		2	6	19	40	21	14	10	5	117	75

Yearly average of total admissions, 1948-63 = 7.3

Yearly average of admissions of severely subnormal 1948-63 = 4.7

*Low = I.Q. < 30
Medium = I.Q. 30 – 50
High = I.Q. > 50

APPENDIX IX

Adult Training Centres and Psychiatric and Psychotherapeutic Day Centres

Admissions and Discharges

	Adult Training Centres			Day Centres		Total		
	Broad Street	Crescent		Cleveland House	Acton Square			
	Males	Males	Females	Females	Males	Males	Females	All
Number on Register, 31st December, 1963								
Subnormal	31	12	44	1	1	44	45	89
Mentally Ill	12	1	1	24	8	21	25	46
Total	43	13	45	25	9	65	70	135
Average Daily Attendance	35	13	35	19	7	55	54	109
Admissions to Centres								
Subnormal	14	11	10	2	5	30	12	43
Mentally Ill	8	1	–	22	18	27	22	48
Total	22	12	10	24	23	57	34	91
Discharges								
Work	6	1	2	1	5	12	3	15
Hospital	1	2	3	1	2	5	4	9
Migrated	2	1	–	–	–	3	–	3
Transferred to other centres	10	1	–	–	1	12	–	12
Excluded	–	1	–	–	1	2	–	2
Defaulted	12	4	10	19	5	21	29	50
Total	31	10	15	21	14	55	36	91

APPENDIX X

Trainees entering employment from Adult Training Centres in 1963

	Age	I.Q.	Period Unemployed	Centre Attendance	Type of Employment	Result
Mentally Ill Males	29		4 months	4 months	Hospital Cleaner	Lost job after 6 weeks
	23		Not known	4 months	Attendant in Bingo Hall	Stable
	24		Previously on remand in Strangeways Prison	3½ months	Rubber Works	Stable
	47		Sporadic Jobs	3 days	Not known	Not known
	21		Not worked before, in remand home	10 months	Painters Labourer	Admitted to hospital under Court Order
Females	45		Many years hospitalised	2 weeks	Egg Breaker Food factory	Stable
	60		3 weeks	3 weeks	Canteen Assistant	Stable
Subnormal Males	31	39	8 months	8 months	Labourer	Not known
	21	84	8 months	8 months	Labourer – Dye Works	Re-admitted to hospital
	24	62	Never worked before	4 years	Labourer – Rag Works	Stable
	34	57	Sporadic Jobs	2 days	Odd job gardening	Most unstable
	19	65	Held sporadic jobs between periods of hospitalisation	3 weeks	Window Cleaner	Re-admitted to hospital
	23	75	18 months	18 months	Porter – Catering firm	Stable
	18	78	11 months	3½ months	Labourer	Not known
Females	16	52	1 year	9 months	Cafe Assistant/Washer Up	Stable

APPENDIX XI

Hostels:– Admissions, Residence and Discharges 1963

Crescent 20 Beds — Kersal 20 Beds

	Males	Females	Total
No. of persons in hostels on 1st Jan.	16	20	36
No. of persons admitted during year:			
One admission only	19	20	39
More than one admission	1	5	6
No. of persons discharged during year:			
One discharge only	26	21	47
More than one discharge	1	6	7
No. of persons in hostels on 31st Dec.	9	18	27
No. of persons who have obtained employment during year, after admission to hostel	5	8	13
Age groups of residents (Ages as at 1st Jan. 1963)			
15 – 19 years	4	9	13
20 – 24 years	9	5	14
25 – 29 years	3	1	4
30 – 34 years	2	2	4
35 – 39 years	3	7	10
40 – 44 years	7	5	12
45 – 49 years	2	7	9
50 – 54 years	2	1	3
55 – 59 years	2	1	3
60 + years	1	4	5

APPENDIX XIA

Reason for Admission by Age and Sex of Hostel Patients Discharged during the years 1962 and 1963

REASON	MALES					FEMALES					Grand Total
	15 –	25 –	35 –	45 –	Total	15 –	25 –	35 –	45 –	Total	
No Home	2	1	5	–	8	4	–	4	8	16	24
Lack of economic resources	–	1	2	1	4	4	–	–	–	4	8
Half-Way House from hospital	7	5	6	–	18	1	2	2	1	6	24
Need for protected environment	6	–	4	3	13	8	1	2	1	12	25
Short term care	2	4	–	3	9	2	3	–	1	6	15
Domestic tension	2	1	2	1	6	5	1	3	–	9	15
Leave from hospital	2	–	–	–	2	3	–	–	–	3	5
En route to hospital	–	–	–	–	–	–	1	1	–	2	2
TOTAL *	21	12	19	8	60	27	8	12	11	58	118

* Excludes two persons from areas of other authorities.

APPENDIX XIB

Reason for Admission by Diagnosis and Sex of Hostel Patients Discharged during the years 1962 and 1963

	MALES							FEMALES							Grand Total
	Psychosis	High Grade Subn.	Medium Grade Subn.	Neurosis	Psychopath	Not determined	Total	Psychosis	High Grade Subn.	Medium Grade Subn.	Neurosis	Psychopath	Not determined	Total	
No Home	5	1	1	–	–	1	8	6	2	3	1	3	1	16	24
Lack of economic resources	2	–	–	–	1	1	4	–	–	–	–	2	2	4	8
Half-Way House from hospital	6	3	3	–	5	1	18	5	–	–	1	–	–	6	24
Need for protected environment	6	2	–	3	2	–	13	3	5	1	3	–	–	12	25
Short Term Care	1	2	6	–	–	–	9	1	–	5	–	–	–	6	15
Domestic tension	4	1	–	–	–	1	6	1	2	2	–	3	1	9	15
Leave from hospital	–	2	–	–	–	–	2	–	3	–	–	–	–	3	5
En route to hospital	–	–	–	–	–	–	–	–	–	2	–	–	–	2	2
TOTAL	24	11	10	3	8	4	60	16	12	13	5	8	4	58	118

APPENDIX XIC

Outcome* by Diagnosis and Sex of Hostel Patients Discharged during the years 1962 and 1963

	MALES		FEMALES		ALL		Total
	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	
Psychosis	11	13	12	4	23	17	40
High Grade Subnormal	7	4	10	2	17	6	23
Medium Grade Subnormal	8	2	13	—	21	2	23
Neurosis	1	2	3	2	4	4	8
Psychopath	4	4	4	4	8	8	16
Not determined	2	2	2	2	4	4	8
TOTAL	33	27	44	14	77	41	118

* Outcome classed as satisfactory

Left by agreement.
Placement (Home, Lodgings foster care)
Return home after short term care.
Following leave from hospital.
En route to hospital

Unsatisfactory

Deterioration and admission to hospital.
Delinquency and Court action.
Left without consultation.
Expelled.

APPENDIX XID

Outcome* by Age and Sex of Hostel Patients Discharged during the years 1962 and 1963

AGE	MALES		FEMALES		ALL		TOTAL
	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	
15 –	9	12	18	9	27	21	48
25 –	7	5	6	2	13	7	20
35 –	10	9	10	2	20	11	31
45 –	7	1	10	1	17	2	19
TOTAL	33	27	44	14	77	41	118

* Outcome classed as satisfactory

Left by agreement.
Placement (Home, Lodgings foster care)
Return home after short term care.
Following leave from hospital.
En route to hospital.

Unsatisfactory

Deterioration and admission to hospital.
Delinquency and Court Action.
Left without consultation.
Expelled.

APPENDIX XIE

Duration of Stay by Age and Sex of Hostel Patients Discharged during the years 1962 and 1963

	MALES					FEMALES					Grand Total	Resident on 31.12.63.
	Age at Admission				Total	Age at Admission				Total		
	15 –	25 –	35 –	45 –		15 –	25 –	35 –	45 –			
Less than one month	6	7	10	6	29	17	5	5	6	33	62	4
1 Month –	6	3	4	1	14	6	2	2	2	12	26	2
3 Months –	4	–	3	1	8	3	1	1	2	7	15	1
6 Months –	3	2	–	–	5	–	–	2	1	3	8	4
9 Months –	1	–	–	–	1	–	–	–	–	–	1	1
12 Months –	1	–	2	–	3	1	–	2	–	3	6	15
TOTAL	21	12	19	8	60	27	8	12	11	58	118	–
In Residence at 31.12.63.	2	–	3	4	9	5	3	4	6	18	27	27

APPENDIX XIF

Duration of Stay by Diagnosis and Sex of Hostel Patients Discharged during the years 1962 and 1963

	MALES							FEMALES							Grand Total
	Psycho-sis	High Grade Subn.	Medium Grade Subn.	Neuro-sis	Psycho-path	Not deter-mined	Total	Psycho-sis	High Grade Subn.	Medium Grade Subn.	Neuro-sis	Psycho-path	Not deter-mined	Total	
Less than one month	14	3	5	1	3	3	29	10	5	8	3	3	4	33	62
One Month –	6	1	1	2	3	1	14	3	4	2	–	3	–	12	26
3 Months –	3	3	2	–	–	–	8	1	2	2	–	2	–	7	15
6 Months –	–	2	2	–	1	–	5	–	–	1	2	–	–	3	8
9 Months –	–	1	–	–	–	–	1	–	–	–	–	–	–	–	1
12 Months –	1	1	–	–	1	–	3	2	1	–	–	–	–	3	6
TOTAL	24	11	10	3	8	4	60	16	12	13	5	8	4	58	118
In Residence at 31.12.63.	4	1	3	–	1	–	9	4	5	5	2	2	–	18	27

APPENDIX XII

Mental Health Department – Staff

	31.12.1962	Resigned 1963	Appointed 1963	31.12.1963
MEDICAL				
Senior Assistant Medical Officer (Part-time)	1	–	–	1
Assistant Medical Officers (Part-time)	2	1	1	2
CONSULTANTS				
Psychiatrist (one session per week)	1	–	–	1
Paediatrician (one session per week)	1	–	–	1
EDUCATIONAL				
Psychologists (sessional work)	3	–	1	4
Remedial Teacher	1	1	2	2
SOCIAL WORKERS				
Social Work Supervisor	1	–	–	1
Psychiatric Social Worker	1	–	–	1
Mental Welfare Officers	6 (inc. 1 part-time)	–	2	8 (inc. 1 part-time)
Trainee Mental Welfare Officers	2	2†	–	–
ADMINISTATION				
Senior Mental Welfare Officer (Admin.)	–	–	1	1
Administrative Assistant	1	–	–	1
Shorthand Typists	2	2	2	2
Clerk	1	1	1	1
TRAINING CENTRES				
Supervisors	3	–	1	4
Assistant Supervisors	14 (inc. 1 temp.)	2	2	14
Centre Assistants	2 (inc. 1 trainee)	1 *	–	1
RESIDENTIAL HOSTELS				
Wardens	2	1	1	2
Assistant Wardens	3	1	1	3

† Appointed Mental Welfare Officers.

* Appointed Assistant Supervisor.

APPENDIX XIII

RESEARCH

1. The Salford Mental Illness Survey continues, being supported by the Medical Research Council through one grant to Dr. Zena Stein, and through a second to Dr. M. W. Susser for Mr. D. Downham who is responsible for the computer programme which is to analyse the survey. Unfortunately, faults in the computer have put the analysis well behind schedule. Dr. A. Adelstein of the Department of Social and Preventive Medicine, Manchester University, is also a member of the survey.

2. The study of epidemiology of mental subnormality is being supported by a grant from the National Association for Mentally Handicapped Children. The main part of the analysis is being made by Dr. A. Kushlick, but since his departure for Wessex Drs. T. Fryers (Medical Officer) and A. Adelstein (Department of Social and Preventive Medicine, Manchester University) have undertaken to continue in some aspects with Dr. M. W. Susser.

3. The controlled trial of Niamid in severely subnormal children, by Dr. R. I. Mackay (Consultant Paediatrician), Dr. Arianne Wiseman (Medical Officer) and Mrs. M. A. Riley (psychologist) has been completed (see J. Ment, Def. Res. 1963). It was supported by the Manchester Regional Hospital Board and they are continuing with further studies.

4. Mrs. I. Hulme (Remedial Teacher) has completed her study of play among subnormal children which she carried out with the help of Dr. Eric Lunzer (Department of Education, Manchester University) during her tenure of the Susan Isaacs Memorial Fellowship.

5. Dr. Eric Lunzer will carry out a further study on the relationship between hearing and the use of language in subnormal children.

6. During the Mayoralty of Mr. Tom Mellor in 1962, he decided to devote the annual mayoral fund to mental health research in Salford. The sum of £4,000 has been placed with Manchester University, and this will now be available for further research in Salford. Under consideration are a social survey to complete the background of Salford Mental Illness Survey, and a follow-up study to pursue some of the implications of the survey. A pilot study has already been carried out.

7. Dr. R. Frankenburg (Department of Sociology, Manchester University) and Dr. Joyce Leeson (Department of Social and Preventive Medicine) have continued their observations at the Stepping Stones Therapeutic Club. The large amount of sociometric and other data which they have collected now awaits analysis.

IMMUNISATION

During 1963 two important changes were made in our routine immunisation programme.

Firstly, a "master-card" was introduced for each baby born in Salford which will contain a summary of all the procedures undertaken during its life. It will mean that the immunisation history will be visible at a glance on one card instead of being on three or four.

Secondly, a change was made in the arrangements for the first immunisation of a baby at about two months of age. Hitherto an invitation was sent by post to the parents, pointing out the need for immunisation and giving an appointment at one of our clinics. It was felt that a personal approach to parents would improve the numbers of children who are immunised. Accordingly, health visitors now obtain the parents' co-operation at one of their early visits to new babies and make arrangement for the first doses to be given often by themselves either at the nearest clinic, or in the child's own home. In this way, any fears or misapprehensions of the mother and father can be dispelled. Subsequent doses are then given by invitation to child welfare clinics at the appropriate times.

Some modifications were made in the timing of the immunisation in the light of advice given by the Ministry of Health and other authorities. Triple vaccine (diphtheria, whooping cough and tetanus) continues to be given as early as possible, and oral polio vaccine is given at the same time and not at six months of age. Smallpox vaccination is deferred until about the first birthday. Reinforcing doses of triple and polio vaccines are given at 18 months: further protection against diphtheria, tetanus and polio is given on entry to school.

After the end of the year, when the new scheme had been in operation about eight months, an examination was made into how it was working. The records of all children born in Salford in 1963 were examined to see the build-up of their immunity month by month, and also the reasons why some children had received no dose of vaccine.

The accompanying table shows the situation which was found.

The first notable point is that about 10 per cent of the children born in the city and regarded as living there, had left before they were six months old. It may be that they are balanced by an equal number who move in but are unknown to the Health Department. Evidence from the 1961 Census, however, seems to show that this is not the case and that there is a loss of population by this age. The effect of this is to underestimate the proportion of children immunised in Salford. (Children who move into Salford and about whom details are known have been placed in the appropriate section of the table.)

It will be seen that by about six months of age, half of the available infants have had three doses of triple vaccine (and most of them polio vaccine as well.) By about a year, the figure rises to over three-quarters. It is known that a number of children have been immunised by their general pract-

itioners without a notification having been sent to the Health Department. By the time they reach the age of eighteen months, it is possible that 90 per cent of Salford children have been immunised.

The table also shows a tendency for the proportion of parents who refuse immunisation for their children, to fall in recent months to half of what it was a year ago. This may be taken to indicate that the new procedure with a personal approach, is having its desired effect.

TABLE

Immunisation of children born 1962 – 1963

Date of Birth	Age at Survey	No. Born	Removals (net loss)	Died	Effective Population		Percentage* Immunised		NO DOSE OF VACCINE				
									Refusal		Deferred illness, etc.	Awaiting dose	First
					No.	%	3 doses	1 or more doses	No.	%		G.P.	H.V.
1963													
Dec.	2 m	263	5	3	255	97	–	32	2	1	6	23	143
Nov.	3 m	243	5	6	232	95	2	49	6	3	15	34	69
Oct.	4 m	286	8	7	271	95	16	57	11	4	13	27	66
Sept.	5 m	267	13	8	246	92	35	67	5	2	14	28	33
Aug.	6 m	246	10	5	231	94	48	72	5	2	14	26	18
July	7 m	301	17	13	271	90	61	80	10	4	12	26	5
June	8 m	262	19	7	236	90	66	78	8	3	15	27	1
May	9 m	246	21	6	219	90	71	84	8	4	10	16	–
Apr.	10 m	250	22	13	215	86	75	86	16	7	6	8	–
Mar.	11 m	298	25	6	267	90	77	85	11	4	6	23	–
Feb.	12 m	243	23	5	215	88	78	85	13	6	5	15	–
Jan.	13 m	298	26	8	264	89	84	89	7	3	4	17	–
1962	14.25m	3209	270	101	2336	89	82	85	217	8	13	191	–

* of effective population

During the year 2,650 children aged 0 – 15 years completed immunisation, this shows a slight increase when compared with the previous year of 2,467. The following figures show the results of the year's work :–

	0 – 5 years	5 – 15 years	0 – 15 years
Number immunised during the year ended 31st December, 1963	2,431	219	2,650
Total completed immunisation at 31st December, 1963	9,629	20,722	30,351
Population figures, 1963	13,700	22,800	36,500
Percentage immunised at 31st December, 1963	70.28%	90.88%	83.15%

The children were immunised as follows:–

At Child Welfare Centres	1,584
By Public Health Nursing Staff in the homes of the children	624
By Nursing Staff at Schools	219
By General Practitioners	222
At Day Nurseries	–
At Hope Hospital	1
	2,650

Of the 2,650 children completing immunisation, 2,431 received diphtheria pertussis and tetanus (triple antigen) injections and 219 received combined diphtheria and tetanus immunisation.

1,718 booster injections of diphtheria and tetanus were given to school children during 1963, and 999 children aged 0 – 5 years were given a booster dose of triple antigen twelve months after the completion of primary immunisation.

Whooping Cough Immunisation

2,431 children were given protection against whooping cough during 1963. This number includes children who have received triple antigen injections.

Poliomyelitis Vaccination

The following figures show the number of doses of oral poliomyelitis vaccinations given during the year:–

	1st dose	2nd dose	3rd dose	4th dose
Children 0 – 5 years 1959-63	3,310	3,022	2,849	107
Children 5 – 15 years 1949-58	396	399	687	1,296
Young people age group 1933-48	87	72	113	–
Older people up to 40 years of age	80	74	113	–

The figures below show the total number of polio vaccinations given at 31st December, 1963.

	Completed Salk & Oral Vaccination	Fourth Salk & Oral Vaccination
0 – 5 years (1959-63)	7,033 50%	127
5 – 15 years (1949-58)	20,455 88%	9,773 42%
0 – 15 years (1949-63)	27,488 74%	9,900 26%
Young persons (1933-48)	16,384 60%	430
Older people to 40 years of age	7,612 14%	–

B.C.G. Vaccination

Appended are statistics relating to Mantoux tests and B.C.G. vaccination, given to 13 year old children :–

	Consents	Positive	Negative	D.N.A.	B.C.G. Vaccination
Boys	664	50	485	129	485
Girls	668	38	505	125	505
Total	1,332	88	990	254	990

Smallpox Vaccination

The figures relating to vaccination during 1963 are as follows :–

Age at date of vaccination in the year	Under 1 year	1 year	2 – 4 years	5 – 14 years	15 years and over	Total
Primary Vaccinations	88	149	32	18	20	307
Re-vaccinations	–	1	5	8	94	108

INFECTIOUS DISEASES

The following table shows the numbers of infectious diseases notified during the year:–

Disease	All ages	Under 1 year	1–5 years	5–15 years	15–25 years	25–45 years	45–65 years	65 years and over
Scarlet Fever	26	–	13	13	–	–	–	–
Whooping Cough	81	11	44	25	1	–	–	–
Measles	1,123	66	751	301	5	–	–	–
Dysentery	45	6	18	11	4	4	2	–
Pneumonia	14	–	3	1	1	1	3	5
Erysipelas	3	–	–	–	–	–	3	–
Food Poisoning	14	–	5	1	2	2	3	1
Opthalmia Neonatorum	3	3	–	–	–	–	–	–
Puerperal Pyrexia	37	–	–	–	29	8	–	–
Rheumatism	4	–	–	4	–	–	–	–
Tuberculosis (Respiratory)	68	–	–	4	9	21	24	10
Tuberculosis (Others)	1	–	–	–	–	–	1	–
	1,419	86	834	360	51	36	36	16

The total number of notifications received is detailed in the foregoing table.

There were two notable absentees from the list – acute poliomyelitis and diptheria. This is not the first year during which there has been no case of poliomyelitis but it is a welcome incentive to our efforts to secure the protection of all children against this crippling disease.

For the fourth successive year there has been no case of diptheria in the city. During the last ten years there have been only three cases – two in 1954 and one in 1959. The change which has occurred in this disease is all the more remarkable when it is recalled that only twenty years ago there were about 500 cases in the city each year. There were only 16 cases in the whole of England and Wales in 1962. Much of this reduction can be attributed to effective immunisation.

In the last five months of the year there was a sharp rise in the number of cases of whooping cough. This was part of a large outbreak which occurred in south-east Lancashire. In a small investigation of 69 of the Salford cases, it was found that 46 of them had never been immunised and another four had had an incomplete course. Of the nineteen who had had at some time a course of immunisation, in thirteen cases this was more than two years before the onset of the disease (in six cases it was five years or more). There is reason to believe that protection begins to wane some two years or so after a primary course if a reinforcing dose is not given. There were, however, six cases in which an apparently adequate course of immunisation

against whooping cough was followed within two years by an attack of the disease. Work done at Manchester University has shown that this may be due to the fact that the vaccine used does not contain antigens for all the varieties of the organism at present in the community. It is understood that the manufacturers are incorporating these other varieties into future supplies of the vaccine.

During the year we have co-operated with the Public Health Laboratory Service in two investigations – one into the complications of measles and the second into deaths from encephalitis.

In the first, which took place in the first four months of the year, the notifying doctors were asked to give additional information regarding complications. It is gratifying to find that only one Salford child had a potentially serious complication but she made a complete recovery. This investigation was planned to assess the need for a measles vaccine, about which a decision has not yet been made.

The second investigation consisted of an enquiry into possible predisposing causes of encephalitis the origin of which is often obscure. Each death from the disease (three in number) was followed up and factors such as minor disease or vaccination were assessed.

Respiratory Tuberculosis continues to be a considerable problem in the city even though there have been changes in the number of notifications and deaths in the last ten years. Recent advances in the treatment of the disease have meant that cases diagnosed early, stand a very good chance of full restoration to health in a short time. In some cases, admission to hospital or even confinement to bed is not required.

The recent changes in Salford are given below :–

	Notifications		Deaths	
	Men	Women	Men	Women
1954	94	69	26	13
1959	84	46	25	6
1963	47	21	9	1

There have been changes also in the ages at which the disease makes itself known. The following table shows some of these and gives the figures for England and Wales for comparison.

Notifications of Respiratory Tuberculosis – Rates per 100,000 population per year

Age Group	MEN				WOMEN			
	Salford 1954-58	England & Wales 1956	Salford 1959-63	England & Wales 1961	Salford 1954-58	England & Wales 1956	Salford 1959-63	England &Wales 1961
0 – 14	35	29	17	16	33	31	16	17
15 – 24	123	111	57	47	104	139	55	52
25 – 44	95	96	86	60	71	79	81	43
45 – 64	182	121	162	83	37	29	16	21
65 & over	127	87	109	74	17	18	17	14

The unfavourable position of Salford compared with the country as a whole is obvious in the case of all men over the age of 15 and in women aged 25 – 44. The rates in Salford are in some cases twice those for England and Wales.

In men, the former high incidence in early adult life is no longer apparent but the peak age for notification remains at 45 – 64. In England and Wales the peak age for women remains 15 – 24 but in Salford it is rather older – although notifications are high in early adult life as well.

The reduction in notification is most obvious in those under 25 and it may be that this reflects the use of B.C.G. to protect school leavers as well as more general changes, for example, the standards of living and of housing.

It is possible that a high notification rate reflects more efficient case finding, but the fact that Salford has a higher death rate from respiratory tuberculosis than the country as a whole, makes it likely that there is in fact a greater incidence in the community.

Death Rates per million population

		Men	Women
Salford	1959-63	210	42
England	1961	100	32

The disease is not notified in the same numbers from all parts of the city as the following list shows :–

Notification Rate per 100,000 population – Yearly average in Salford 1959-1963

Ward	Men	Women
Albert Park	60	42
Charlestown	63	19
Claremont	62	41
Crescent	140	45
Docks	97	20
Kersal	34	22
Langworthy	63	21
Mandley Park	36	32
Ordsall Park	80	33
Regent	136	20
St. Matthias	143	22
St. Pauls	57	43
St. Thomas	127	40
Seedley	42	16
Trinity	184	24
Weaste	59	25

It will be seen that for men, the rate is highest in Trinity and then gradually decreases towards the north and west of the city. It is often felt that poor housing conditions, especially overcrowding, lead to the spread

of tuberculosis, but other social factors – diet, smoking, etc. also play a part and it is not easy to distinguish the part each plays. The apparent influence of overcrowding can be seen in the following table which relates only to men.

Notifications per 100,000 per year – Salford 1960-1963 – Men

Person per room 1961 Census	Ward	Notification Rate
0.75	Regent	
0.73	Trinity	149
0.73	Crescent	
0.72	Ordsall Park	
0.72	St. Pauls	81
0.70	Charlestown	
0.70	St. Matthias	
0.67	Albert Park	
0.67	Langworthy	
0.66	Kersal	64
0.66	Docks	
0.66	St. Thomas	
0.66	Weaste	
0.65	Mandley Park	
0.59	Seedley	48
0.59	Claremont	

The same pattern is not seen with women, however, who, on the whole, spend more time in their homes. This is largely due to a high rate in Claremont and a low rate in Regent ward, but the total number of notifications for women is small.

The other index of overcrowding we have (the proportion of the population who are living at more than 1½ persons per room) shows no relation with notifications, either with men or with women.

One index we have, which in a way measures the amount of tuberculosis in the community is obtained in connection with the giving of B.C.G. vaccine to school children about the age of 13 years. A preliminary skin test is given to determine whether natural infection with tuberculosis has already occurred. A positive skin test will almost always now mean infection from a human source, as milk borne tuberculosis is very uncommon.

The percentage of positive tests in recent years is as follows:–

	Boys	Girls
1956	24	22
1957	23	24
1958	16	18
1959	19	14
1960	10	10
1961	13	8
*1962	–	–
1963	9	7

*No results are given for 1962 because the children who would have been tested that year were in fact tested in a special investigation carried out for the Medical Research Council in 1961 to assess various methods of giving the B.C.G. vaccine.

It is fairly certain that the percentage of children aged 13 who have been previously infected with tuberculosis is falling. (The percentages in England and Wales for boys and girls were 18 in 1958 and 14 in 1961). It is necessary to be cautious about these figures, however, in that only about half the parents of the children of the appropriate age group wish their children to be protected against tuberculosis. This is well below the national average of 68 per cent.

The lessons to be learnt from this analysis of recent tuberculosis in the city are that we could well concentrate our attention on particular areas among particular age groups if we wish to find early cases of tuberculosis which have not spread the infection to others.

AMBULANCE SERVICE

The following table gives particulars of patients carried and mileage run during 1963, as compared with the previous year:—

Class of Patient	1963		1962	
	Patients	Miles	Patients	Miles
Spastics	4,802	6,419	4,988	6,768
Midwifery	2,526	11,215	2,769	12,458
House Conveyance	63,191	162,554	60,036	160,022
Inter-Hospital	2,752	13,103	2,112	11,912
Maternity	1,649	10,445	1,554	9,965
Gas/Air	414	1,545	487	1,869
Mental Health	6,790	16,276	6,638	15,618
Rechargeable	289	3,006	250	3,129
Emergency	4,510	19,188	4,178	17,824
Miscellaneous	—	3,708	—	2,721
Infectious	151	1,012	206	1,336
Handicapped Persons	2,603	1,981	2,399	1,999
Total	89,677	250,452	85,617	245,621

During the year, ambulances carried 78,395 patients and travelled 200,204 miles, and sitting-case cars carried 11,282 patients and travelled 50,248 miles.

At the end of the year there were in operation ten ambulances, three sitting-case ambulances and two sitting-case cars. The staff consisted of an Ambulance Officer, a Deputy Ambulance Officer, a Station Officer, three Shift Leaders, and thirty-eight Driver/Attendants.

Replacement vehicles introduced during the year were of a larger type of ambulance which carries four stretchers. The last two years have been notable for a changeover to white as the finishing colour for the vehicles in our fleet. All new vehicles are in this colour and it is hoped that present vehicles which still have several years of service remaining will be re-painted in white.

At the end of the year, the new Ambulance Station in Charles Street was nearing completion. Although the work had proceeded very rapidly it was falling behind schedule in the final stages. Transfer to the new premises will take place early in 1964.

HEALTH EDUCATION

The Health Education Section works in close co-operation with other sections, to bring home to the public the services that are available through the Health Department. This is done through articles to the press, advertising, and whenever possible addressing associations, clubs, and sundry groups of people to let them know the ways of better, fuller health. Full use is made of visual aids, particularly filmstrips, to give a more vivid illustration of facts relating to health.

HEALTH SURVEY

As usual a prominent feature of the year's activities was the Health Survey and the visit of the Regional Hospital Board's Mass Radiography Unit for a period of 8 weeks – one week more than in 1962.

4,488 attended for the general tests of the Health Survey – an increase of nearly 500 on the previous year. These tests, which were entirely voluntary, were for the detection of anaemia, diabetes, blood pressure, etc. 3,740 took the eye tests, of which 81 were referred to the family doctor and 279 to the optician. Women attending the Survey were asked whether they would like to have the cervical smear test at a later date.

Another innovation was the attendance of a lady representative from the Citizens Advice Bureau for anyone with personal or family problems to consult.

An indication of the increasing awareness of the importance of chest X-rays was shown by the attendance of 8,571 people.

ANTI-SMOKING CLINIC

The anti-smoking clinic has continued for most of the year. The sessions, held every Monday evening, commence with a talk underlining the hazards to health caused by smoking. Often a filmstrip is shown emphasising particular dangers. But the part of the evening that has proved most beneficial is the "group therapy" – the members relating to each other their times of difficulty and methods of success, and thus quite a number have been able to give up smoking altogether.

HOME SAFETY

Home accidents treated at Salford Royal Hospital during 1963:

	Male		Female		Total	
	Fatal	Non-fatal	Fatal	Non-fatal	Fatal	Non-fatal
Burns and Scalds	1	239	1	215	2	454
Falls	1	674	7	976	8	1,650
Lacerations	–	570	–	429	–	999
Poisoning	1	100	1	72	2	172
Overdose	2	102	3	137	5	239
Dog and Cat bite	–	75	–	50	–	125
Assault	–	10	–	39	–	49

	Male		Female		Total	
	Fatal	Non-fatal	Fatal	Non-fatal	Fatal	Non-fatal
Gas Poisoning	2	11	2	16	4	27
Swallowed Foreign Bodies	–	125	–	96	–	221
Miscellaneous	1	1,765	–	1,426	1	3,191
	8	3,671	14	3,456	22	7,127

The Hospital estimated that about half of those treated were resident in Salford.

An Exhibition was staged by the Home Safety Committee in collaboration with organisations specifically interested in the prevention of accidents in the home, such as the St. John's Ambulance Brigade, the Fire Service, The Royal Society for the Prevention of Accidents, etc. Though a lot of work was put into the organisation of the Exhibition, the public response was poor, and demonstrated how much work needs to be done in arousing public concern at the growing number of unnecessary accidents in the home.

VENEREAL DISEASES

Publicity was continued by means of posters and use of the filmstrip "Venereal Diseases".

SALFORD HOUSE

Salford House provides separate cubicle accommodation for 285 men, and its primary function is to provide temporary shelter for those requiring it.

During 1963 the charges were maintained at 28/- per week or 4/6d. per night, and the average number of residents was 283 per night.

While never losing sight of the hostel's basic function – to provide shelter for all men temporarily in need, the hostel has endeavoured to develop along two main lines :–

(1) the permanent residents, mainly old aged pensioners who make up 60% of the hostel population, and others of younger age groups, who are in some way social problems, but can live happily in a large sympathetic group,

(2) the new admissions, mainly men without family ties, who stay a few days then move on. These men in the main move around the country, never staying longer than a few weeks in any one place, but the majority return to Salford House every year.

The permanent residents make full use of the various services provided by the local authority i.e. the Health Visitor who is a regular caller, and the Chiropodist who attends Salford House monthly. The N.A.B. continue to work in close liaison with the management, and provide many needy cases with extra allowances and clothing grants. The W.V.S. and Booths Charities also provided clothing and footwear to several pensioners.

The Christmas Dinner was again a great success and 150 pensioners and disabled men enjoyed a traditional meal.

The City of Salford Companionship Circle for the Elderly donated gifts to all old aged pensioners, and the almoner and nursing staff of the Manchester Dental Hospital made gifts of cigarettes, tinned foods, etc. to 60 residents.

The social club is now well established and making a small profit after some lean years. The club which is maintained by the residents and run by a residents committee, provides T.V. and billiards and has a snack bar which supplies a wide variety of meals at very low prices. A roster of volunteers has been formed by club members to ensure that any resident of Salford House who may be admitted to a local hospital, shall have someone to visit him and take him small gifts. Other interests are now being developed by the club, and we now receive and entertain snooker and darts teams from local clubs. There is also a Social Evening held once a month, and club members bring their friends. These activities are of immense benefit to the residents of this hostel, and help the residents to develop friendly relations with their fellows, and remove many of the problems facing a stranger in strange surroundings.